



The Centers for Medicare and Medicaid Services:
SUPPORT Act Section 1003 Grant

Hepatitis C Webinar

SEPTEMBER 8, 2020

Department of Medical Assistance Services

Welcome and Meeting Information

- All Webex participants are muted for this event.
- If you have any questions, please use the Q&A feature.
- If you are having technical issues, please type questions or comments in the chat box.
- The webinar recording and a copy of today's slides will be posted on the DMAS ARTS webpage

Agenda

Time	Topic	Presenter(s)
3:30 – 3:35	Webinar Welcome	Christine Bethune, MSW, SUPPORT Act Grant Coordinator, Department of Medical Assistance Services
3:35 – 3:45	Virginia Medicaid Policy Updates, Prior Authorization, and Current Treatment Rates	Chethan Bachireddy, MD, MSc, Chief Medical Officer, Department of Medical Assistance Services
3:45-3:55	Virginia Hepatitis C Rates	Kaitlyn Hauter, MPH, Viral Hepatitis Program Coordinator and Nicole Barron, MS, Viral Hepatitis Testing Coordinator, Virginia Department of Health
3:55-4:15	Hepatitis C Treatment Guidelines	Rebecca Dillingham, MD, MPH, University of Virginia School of Medicine
4:15-4:35	Interrupted HCV Treatment Courses: Cases and Lessons Learned from the National Clinician Consultation Center	Cristina Gruta, PharmD, Senior Consultant, UCSF National Clinician Consultation Center
4:35-4:45	Clinician resources: the National Clinician Consultation Center and more!	Carolyn Chu, MD, MSc, Clinical Director, UCSF National Clinician Consultation Center
4:45-4:50	Hepatitis C Project ECHO Information	Terry Knick BSN-BC, MPH, University of Virginia School of Medicine
4:50-5:00	Q&A	

MEDICAID, HEPATITIS C, AND OPIOID USE DISORDER: A CALL TO ACTION

Chethan Bachireddy, MD, MSc
Chief Medical Officer

Virginia Department of Medical Assistance Services



Medicaid Expansion is Here!

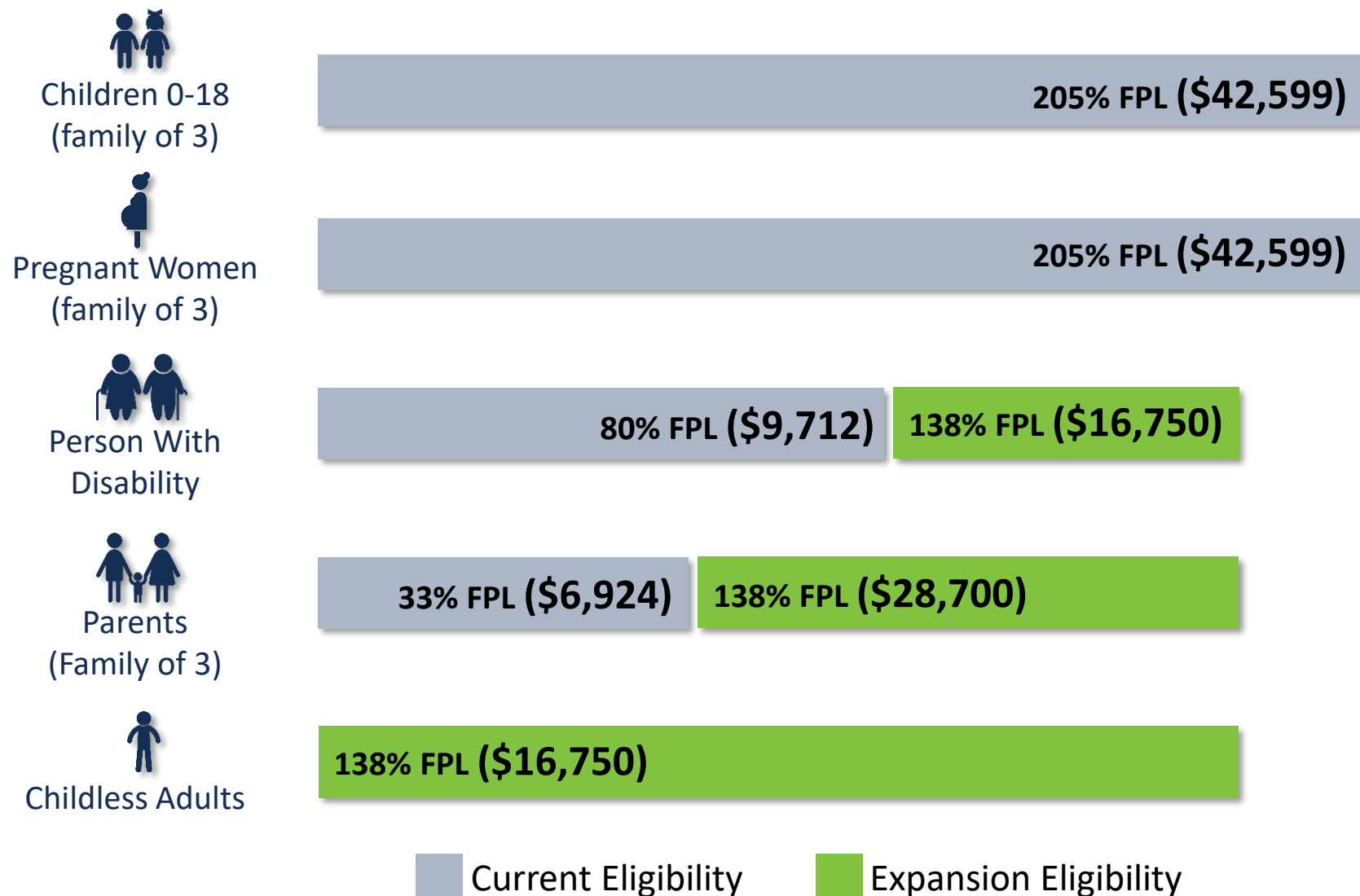
- **The rules have changed.** Up to 400,000 more low-income Virginia adults are eligible for low- and no-cost health coverage
- People working in retail, construction, childcare, landscaping, food service or other jobs that do not offer health insurance may be eligible

456,969



Applications for new adult coverage are now being accepted!

Who Qualifies After Medicaid Expansion?



New Adult Coverage Uses Current Health Plans

Coverage will be provided for most individuals through the Medallion 4.0 and Commonwealth Coordinated Care Plus (CCC Plus) managed care programs



aetna[®]

Aetna Better Health[®] of Virginia



Anthem. HealthKeepers Plus
Offered by HealthKeepers, Inc.



Magellan
COMPLETE CARE[®]



OptimaHealth[®]



UnitedHealthcare[®]
Community Plan



VirginiaPremier[™]
Powered by **VCU Health**

Medicaid's six current health plans will serve the new adult members

How to Apply for Medicaid Coverage



Call the Cover Virginia Call Center at 1-855-242-8282 (TDD: 1-888-221-1590)



Complete an online application at Common Help:
www.commonhelp.virginia.gov



Complete an online application at The Health Insurance Marketplace:
www.healthcare.gov



Mail or drop off a paper application to your local Department of Social Services (mailing may take longer than other methods of applying.)

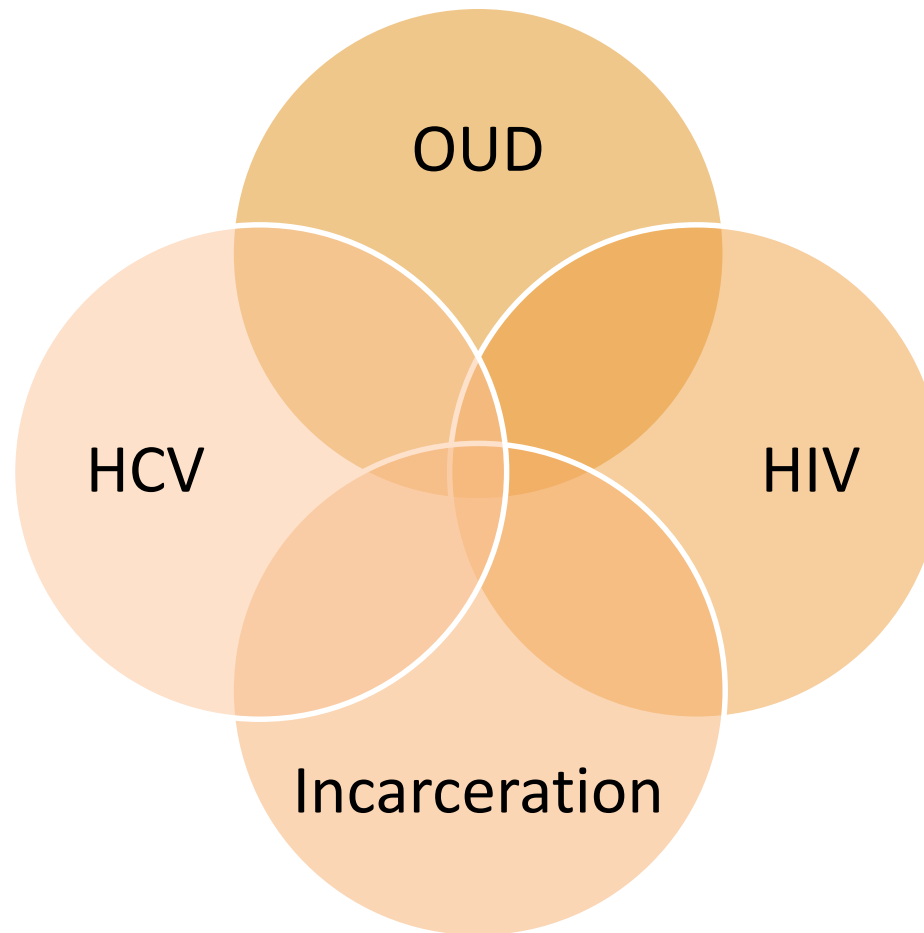
Find your nearest local Department of Social Services by visiting:
<http://www.dss.virginia.gov/localagency/index.cgi>



Call the Virginia Department of Social Services Enterprise Call Center at 1-855-635-4370 (if you also want to apply for other benefits)

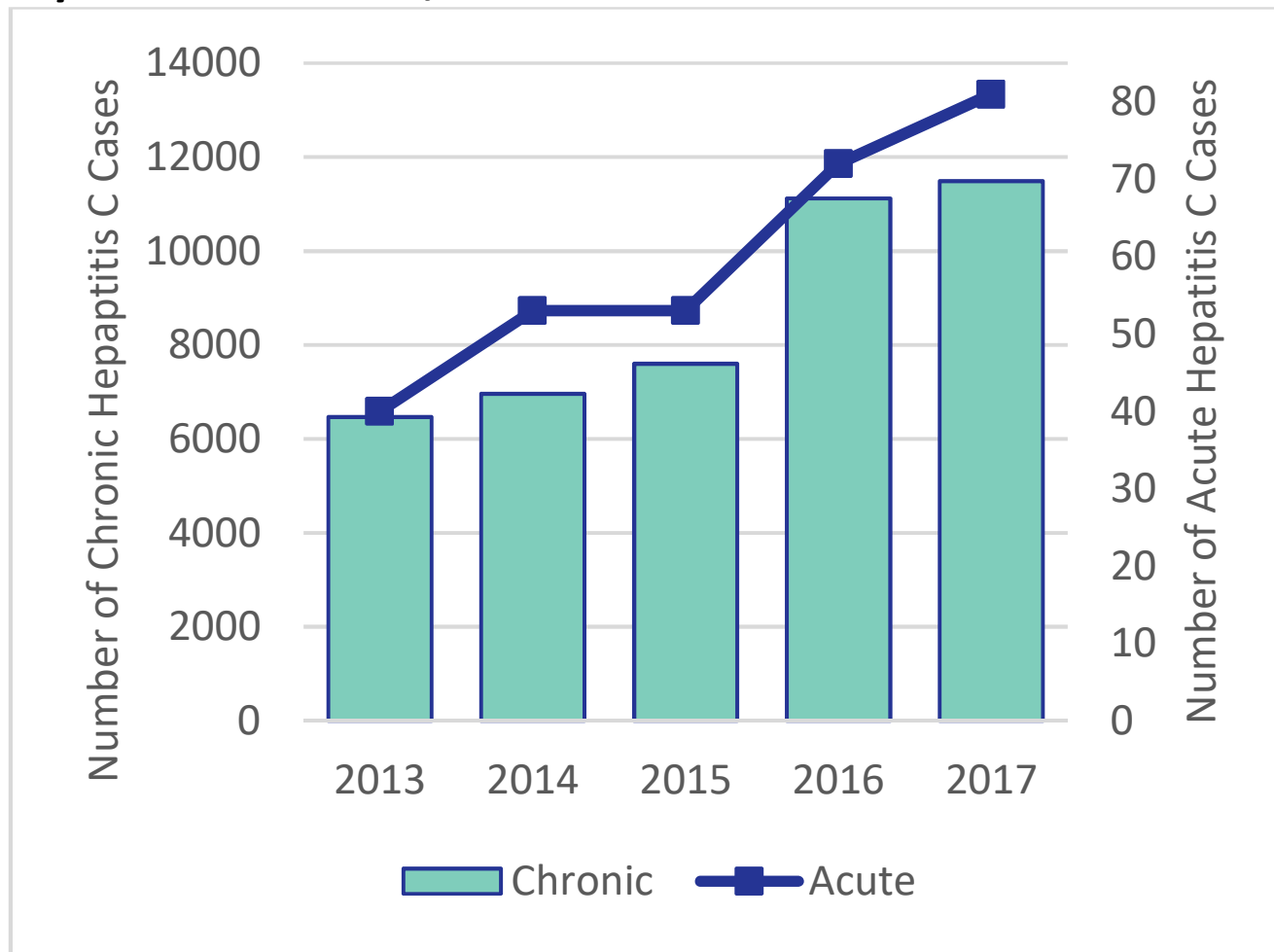
Applications for new adult coverage are now being accepted!

The Syndemic



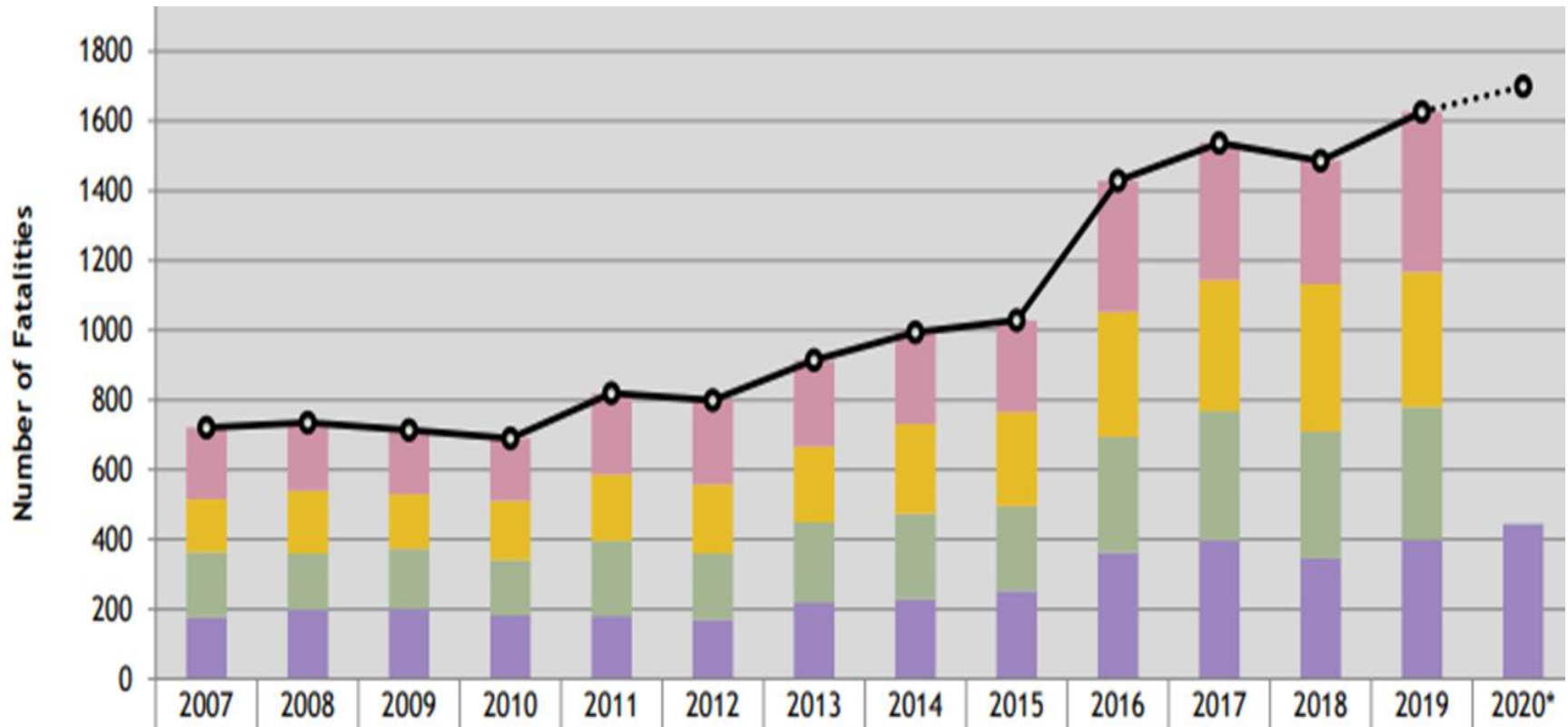
Virginia's Hepatitis C Epidemic

Acute and Chronic Hepatitis C Cases 2013-2017 (VEDSS)

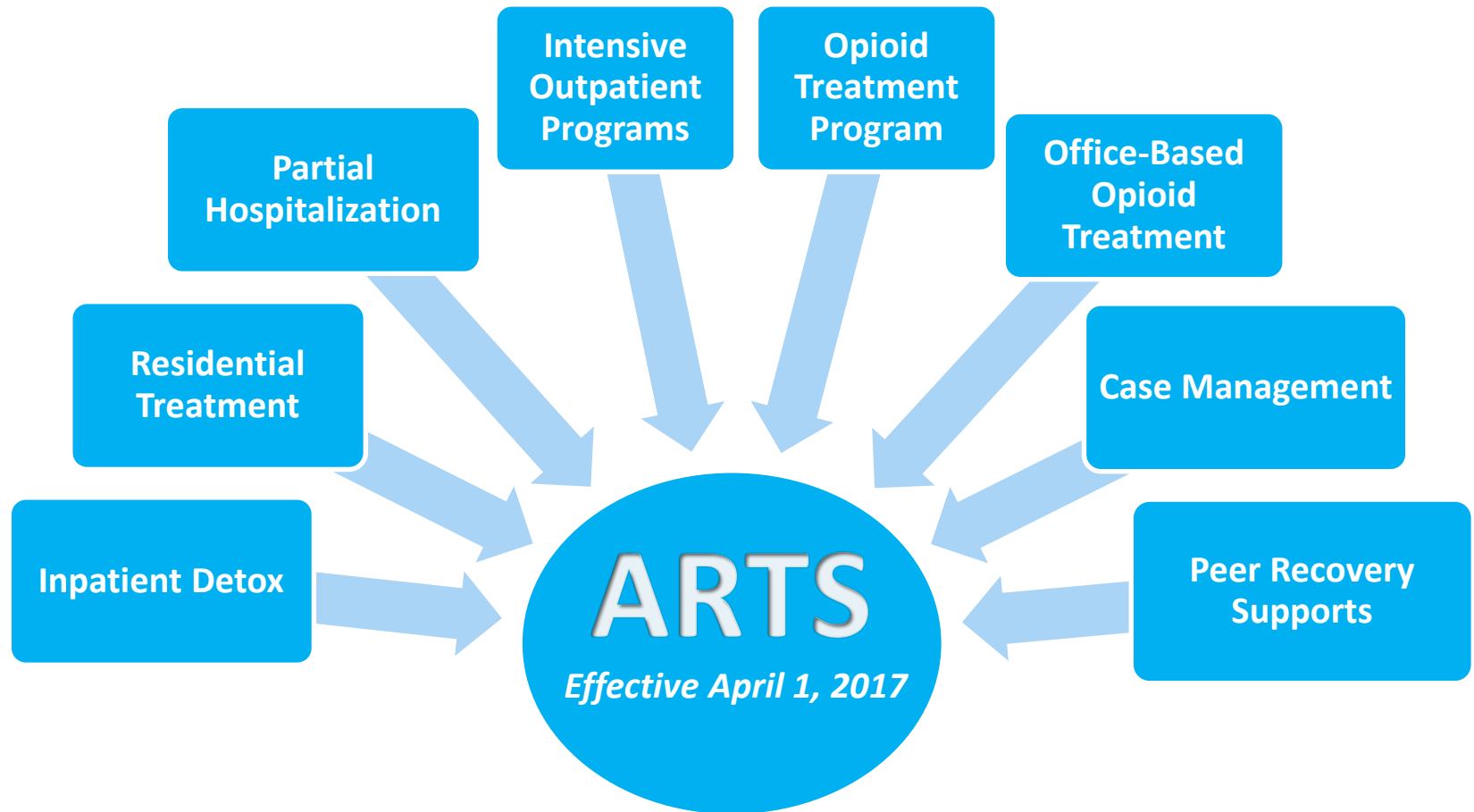


Virginia's Opioid Epidemic

Total Number of Fatal Drug Overdoses 2013-2020*



Addiction and Recovery Treatment Services (ARTS)



ARTS creates a fully integrated physical and behavioral health continuum of care

Number of SUD-Related ED Visits per 100 Medicaid Members with SUD¹

	Before ARTS Apr 2016 - Mar 2017	ARTS Year 1 Apr 2017 - Mar 2018	ARTS Year 2 Apr 2018 - Mar 2019	Percentage change since before ARTS
All SUD-related ED visits per 100 members with SUD	56	54	52	-7.1%
ODU related ED visits per 100 members with OUD	31	24	21	-32.3%
AUD related ED visits per 100 members with AUD	75	70	73	-2.7%

¹Members enrolled through Medicaid expansion are excluded to maintain comparability with prior years

Hepatitis C Medicaid Policy

Recent updates in the past 2 years

- No sobriety restrictions
- No liver damage restrictions
- Generalists and specialists can prescribe
- Mavyret (glecaprevir/pibrentasvir) and Epclusa (sofosbuvir/velpatasvir) available with abridged prior authorization form
- Encourage (but not required) screening and referral for substance use disorder
- Preferred OBOTs now asked to implement universal screening and referral for HCV

State of Emergency ARTS Policy Changes

Policy Flexibilities for SUD Delivery during COVID-19

- **Telehealth (including telephonic) delivery** of all substance use disorder services.
 - “Home” as an originating site
 - Payment parity
 - Buprenorphine induction
- **14 day grace period** for submission of Service Authorizations
- **Flexibility around hourly requirements** for ASAM Levels 2.1 and 2.5
- Medicaid **eligibility and enrollment** flexibilities

State of Emergency ARTS Policy Changes

Policy Flexibilities for SUD Delivery during COVID-19

- **Allowance for Opioid Treatment Programs to be reimbursed** for delivery of medications to member's location as well as take-home dosage administration.
- Allowance for up to **90 day prescription for routine medications, including buprenorphine products.**
- **Flexibilities of urine drug tests and counseling requirements** for individuals to receive pharmacotherapy for SUD treatment.

How Can We Be Part of the Solution?

- 1) **Identify**: Screen and refer for HCV, HIV, and SUD
- 2) **Get the X**: Go through the online or in-person 8 hour training to prescribe Buprenorphine
- 3) **Treat**: Pilot MAT and HCV treatment in your facility and sign up to be a Preferred OBOT for enhanced rates

THANK YOU!

Chethan Bachiredy

chethan.bachiredy@dmass.virginia.gov

Virginia Hepatitis C Rates

September 8, 2020

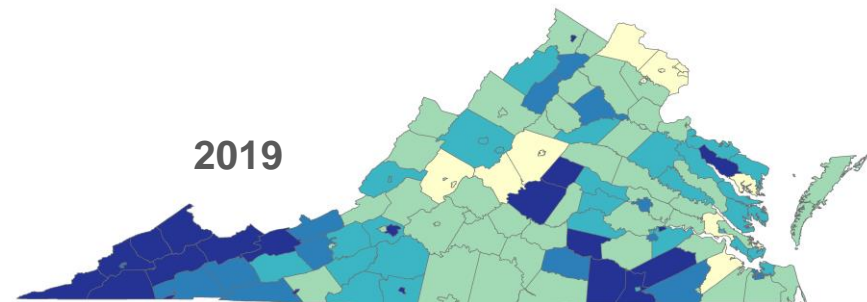
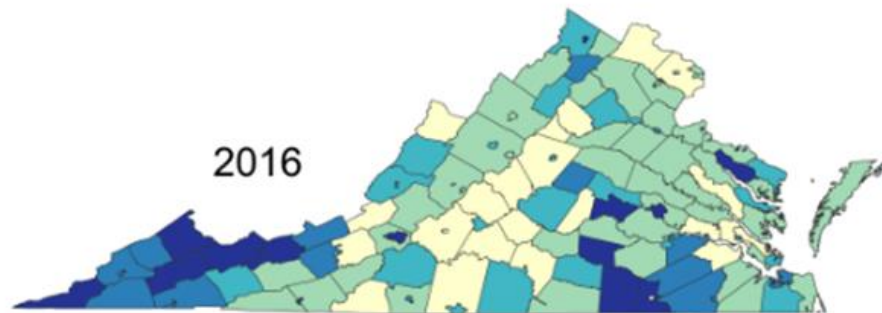
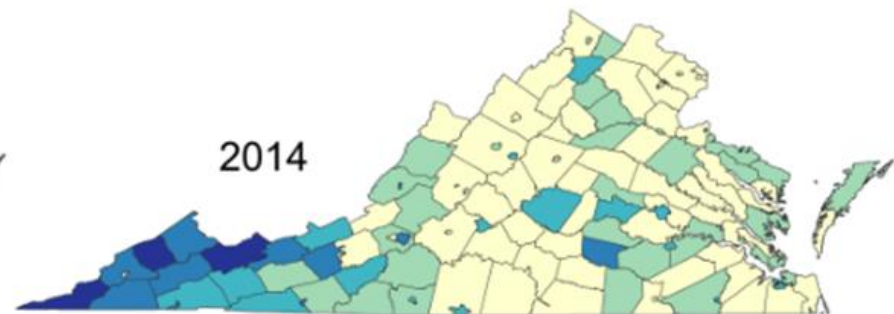
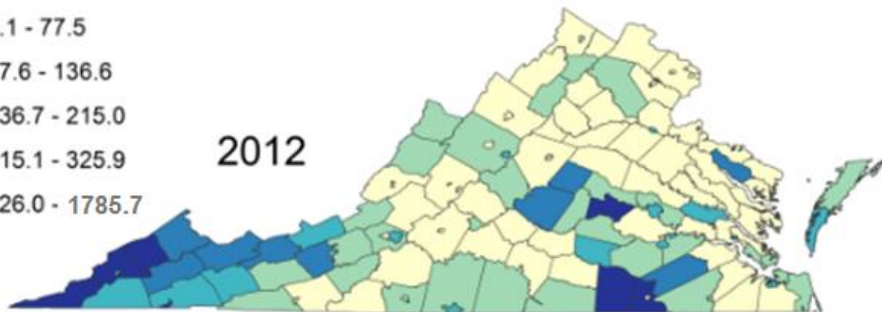
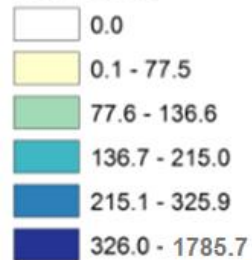
Kaitlyn Hauter, MPH

The Hepatitis Team

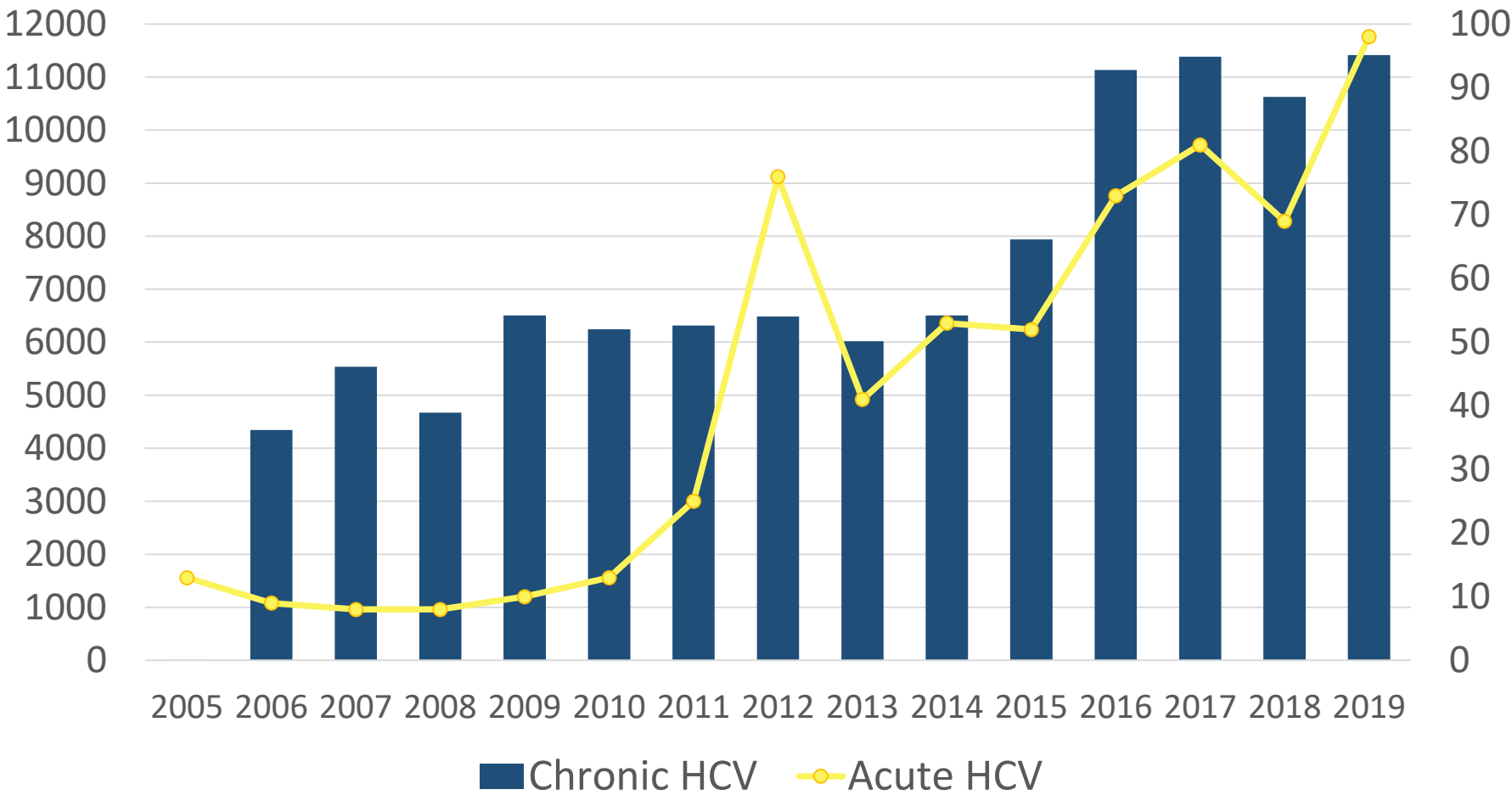
Nicole Barron, MS Viral Hepatitis Testing Coordinator	Nicole.Barron@vdh.Virginia.gov (804) 864-7350
Rachel Stallings, MPH Viral Hepatitis Epidemiologist	Rachel.Stallings@vdh.Virginia.gov (804) 864-7992
Kaity Hauter, MPH Viral Hepatitis Program Coordinator	Kaitlyn.Hauter@vdh.Virginia.gov (804) 864-7593

Time Progression of HCV Rates by County per 100,000 persons (including incarcerated individuals)

HCV RATE

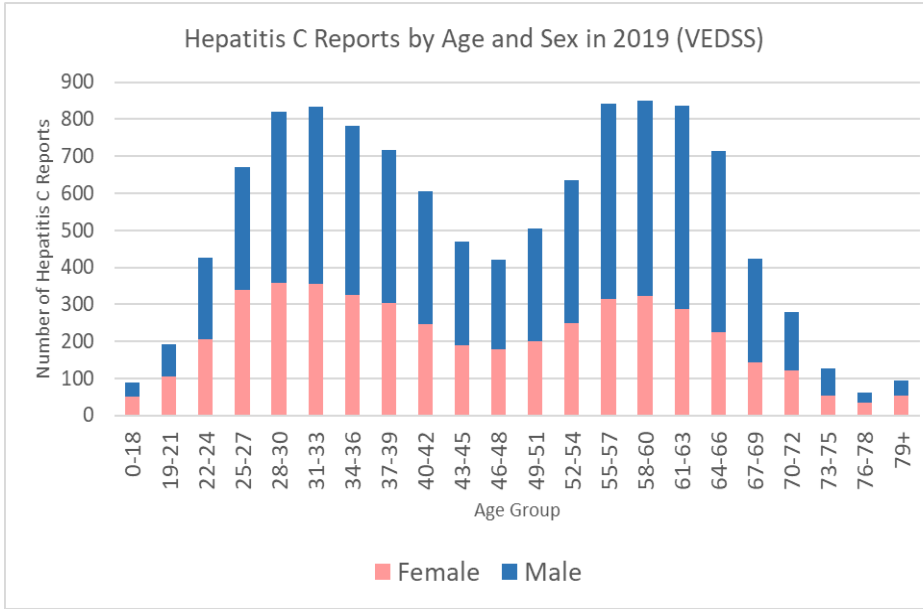
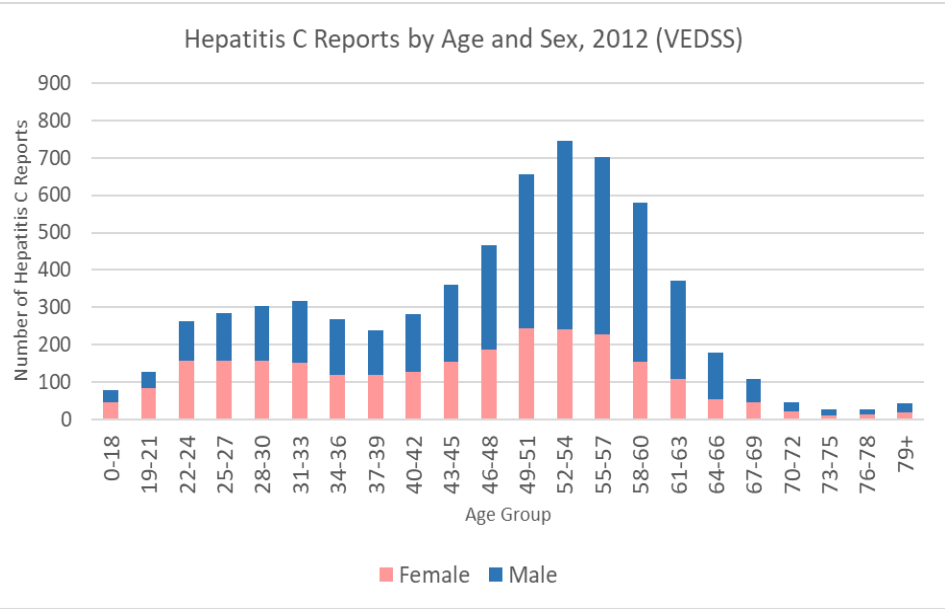


Acute and Chronic Hepatitis C Reports by Year



VEDSS data as of 8/25/20

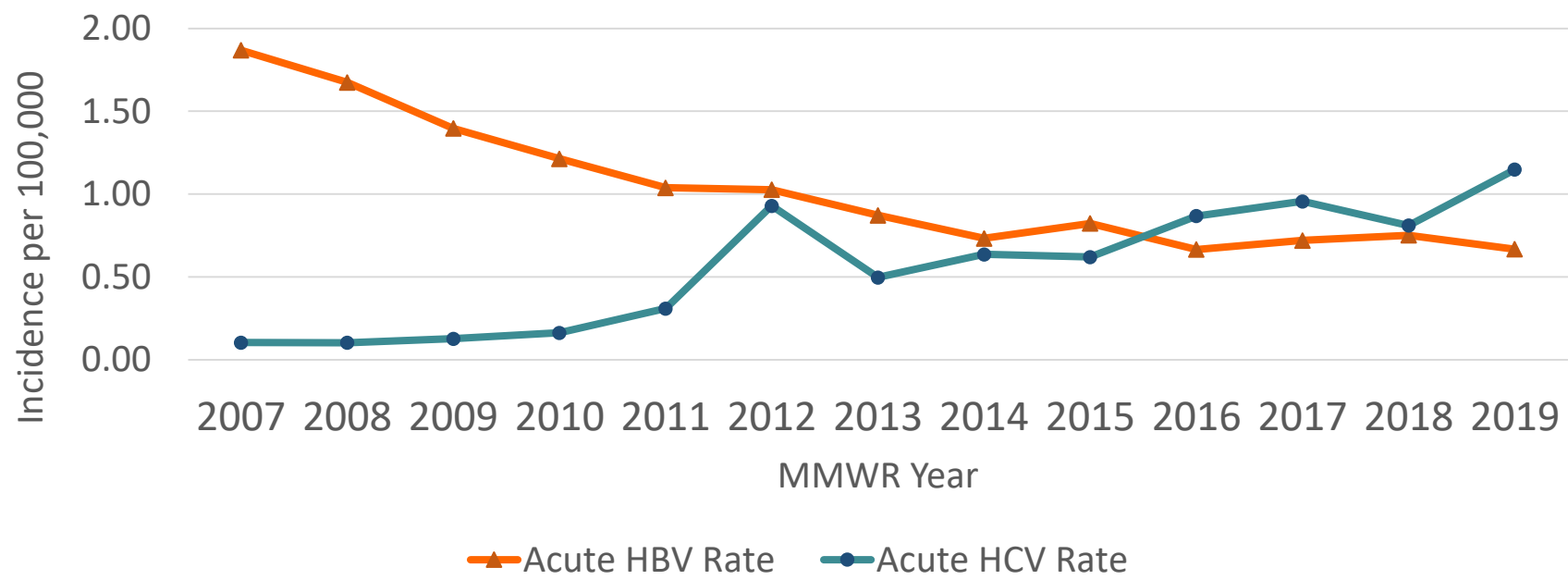
Hepatitis C Reports by Age and Sex



VEDSS data as of 3/5/20

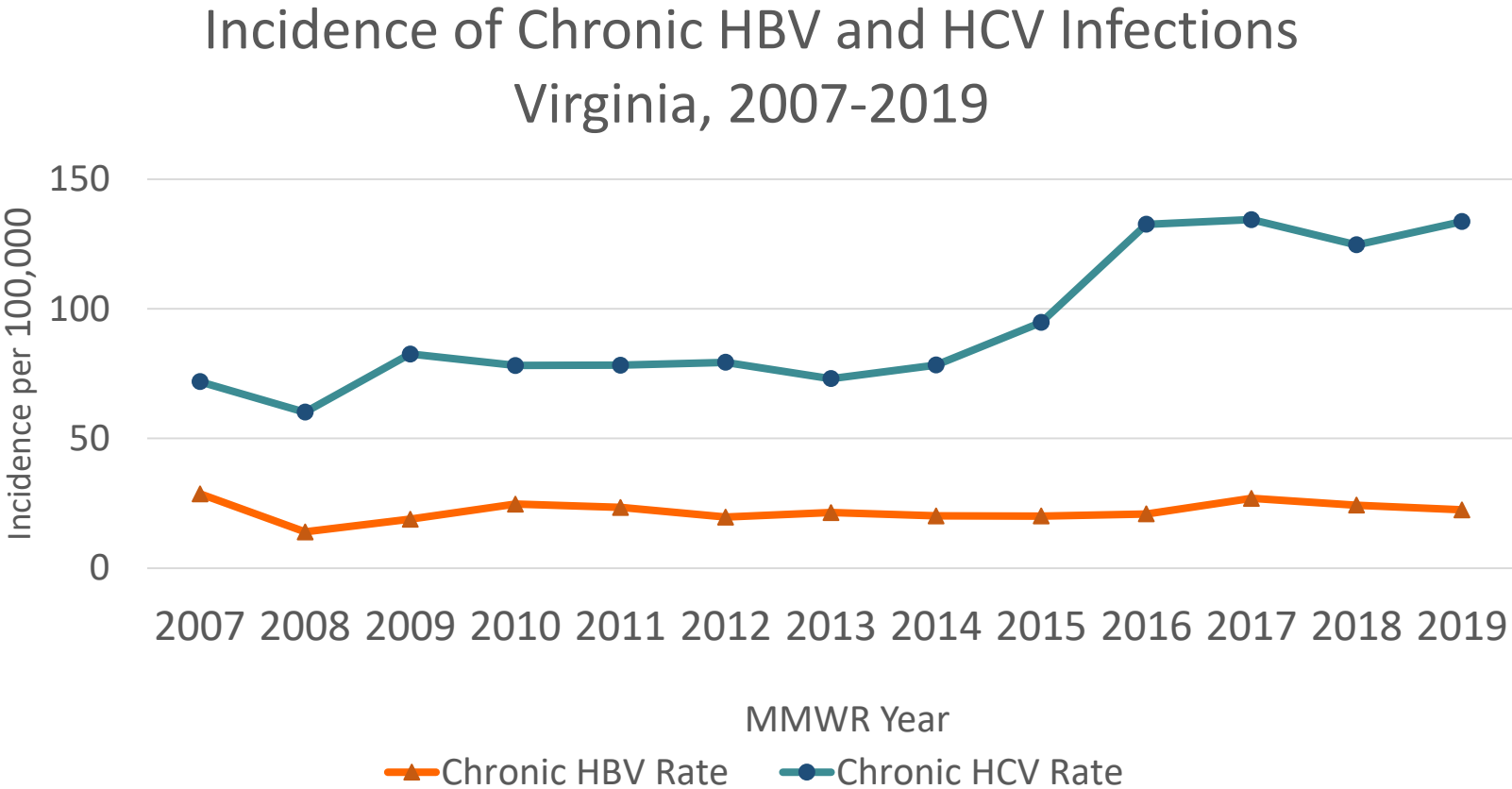
- Declining incidence of acute hepatitis B in Virginia mirrors national trends
- Increasing acute hepatitis C trends since 2009

Incidence of Acute HBV and HCV Infections Virginia, 2007-2019



VEDSS data as of 8/25/20

- A case definition change may account for some of the increase in hepatitis C from 2015 to 2016, but a true increase is also a likely contributing factor

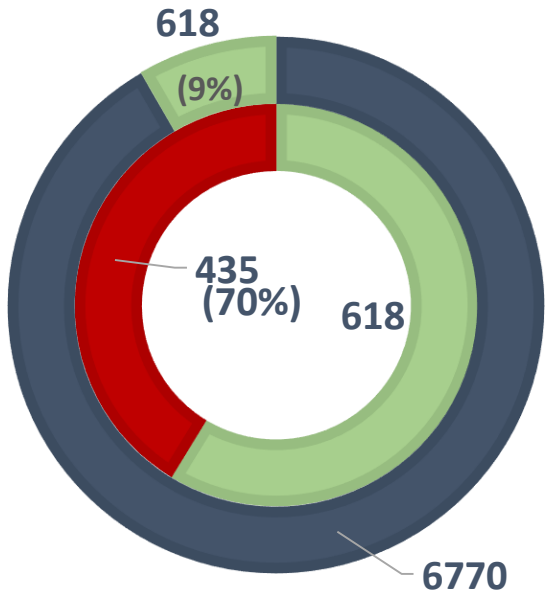


VEDSS data as of 8/25/20

Conventional (clinic-based) Hepatitis C Testing

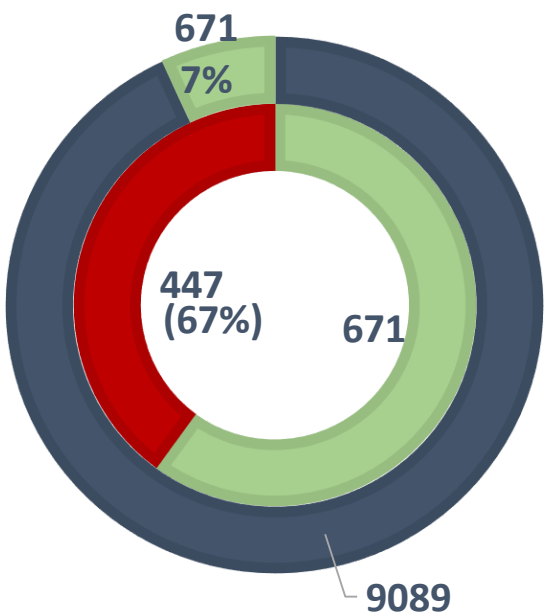
NUMBER OF HCV TESTS (2018)

■ HCV Ab + ■ RNA Confirmed



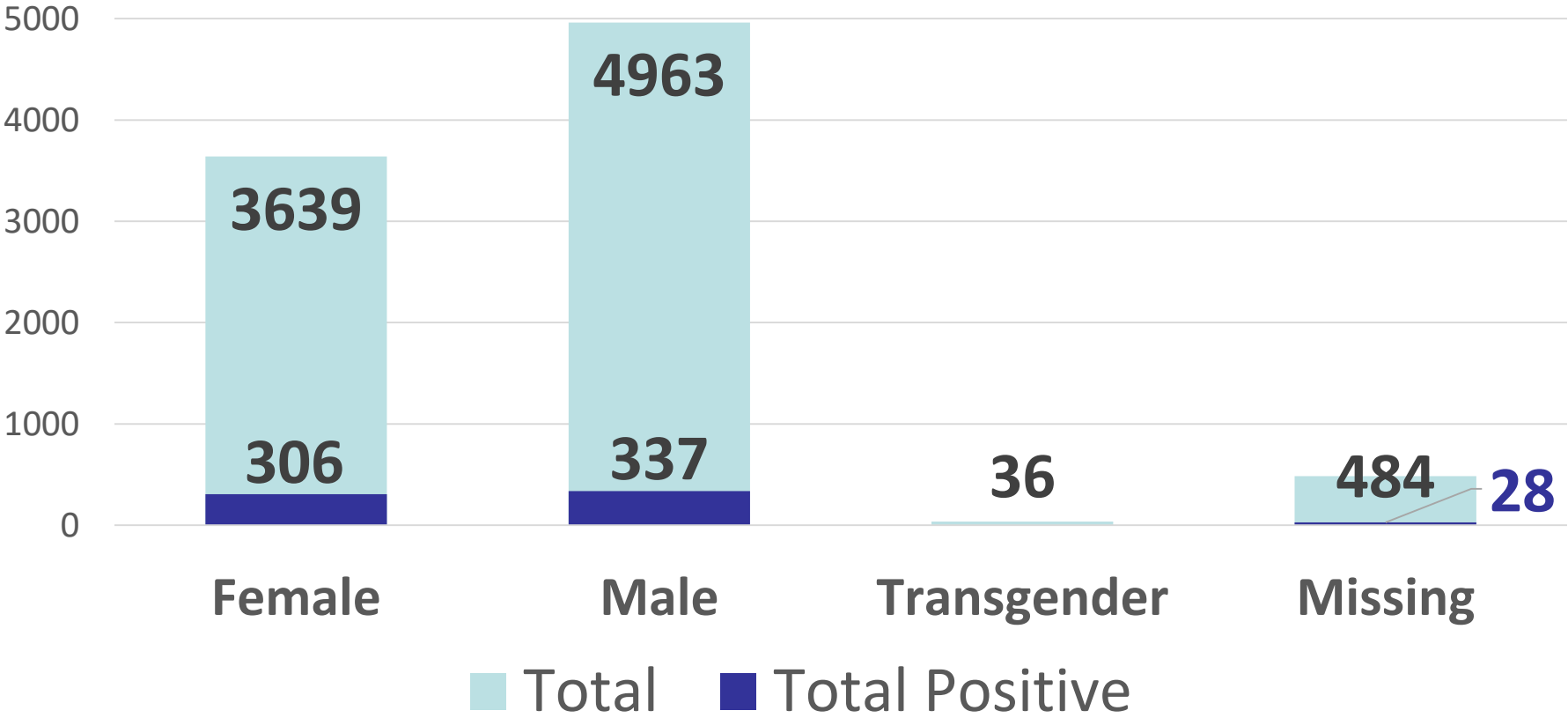
NUMBER OF HCV TESTS (2019)

■ HCV Ab + ■ RNA Confirmed



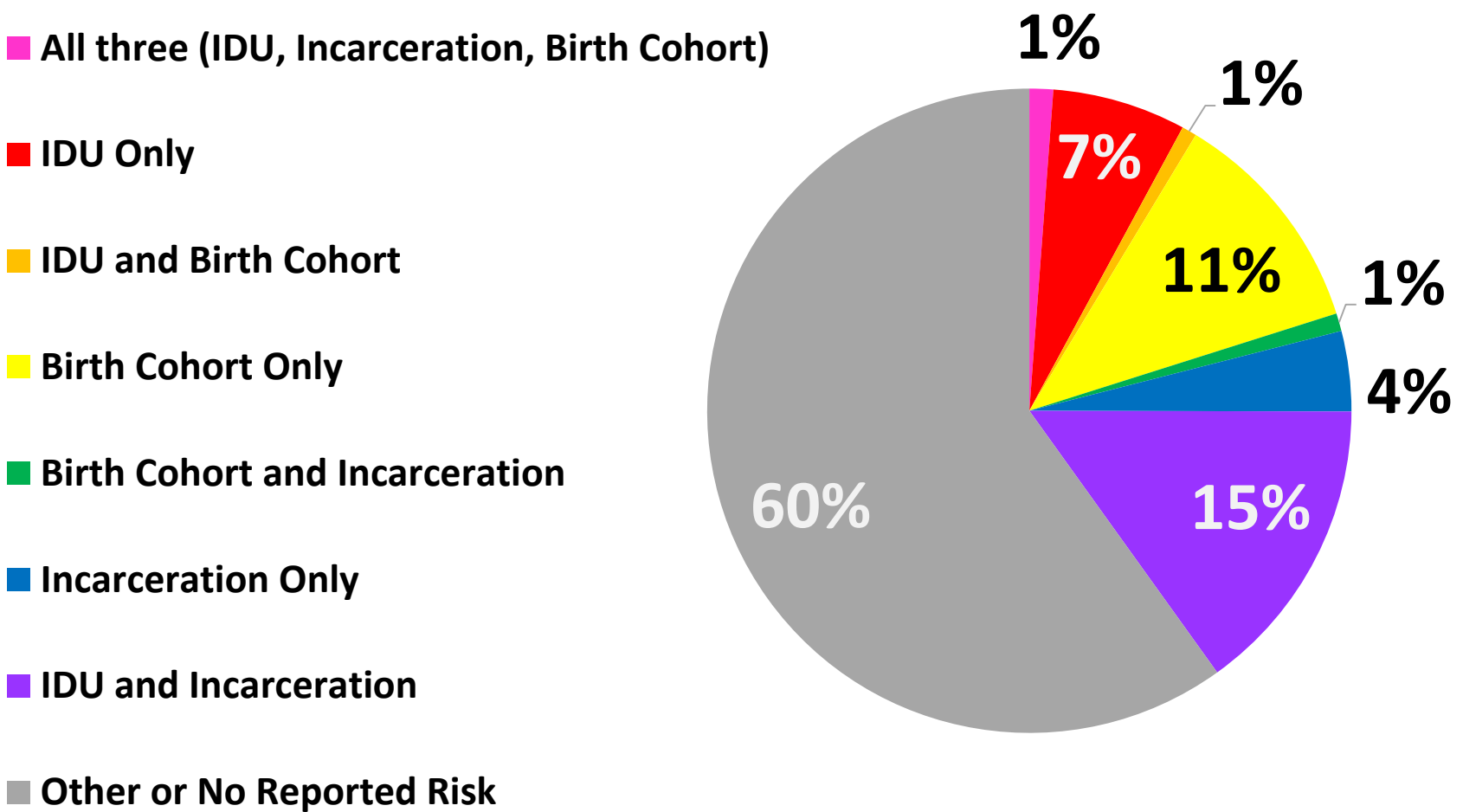
Source: DDP Hepatitis Testing Database, as of 8/24/20

Patient Demographics for Conventional HCV Testing, 2019



Source: DDP Hepatitis Testing Database, as of 8/24/20

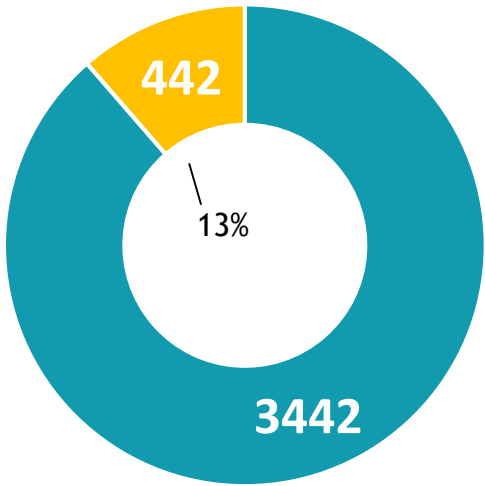
Common Reported Risk for Persons with Positive Conventional Test, 2019



Source: DDP Hepatitis Testing Database, as of 8/24/20

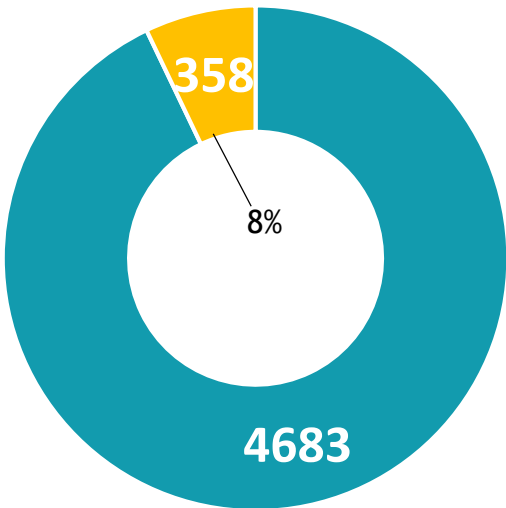
Rapid (non-clinical) Hepatitis C Testing

Number of HCV Rapid Tests (2018)



■ Total Rapid Ab Tests ■ HCV Ab +

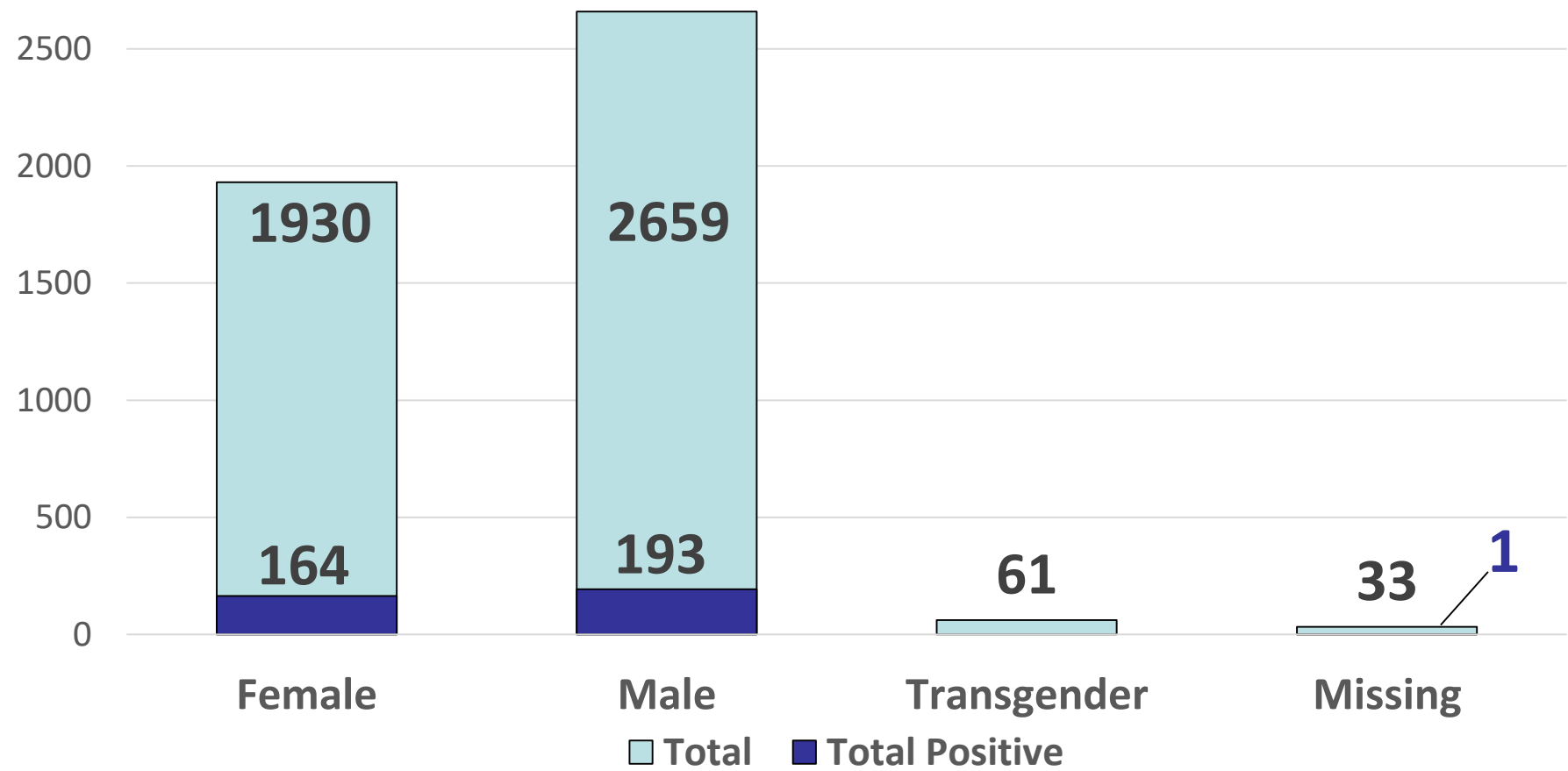
Number of HCV Rapid Tests (2019)



■ Total Rapid Ab Tests ■ HCV Ab +

Source: DDP Hepatitis Testing Database, as of 8/24/20

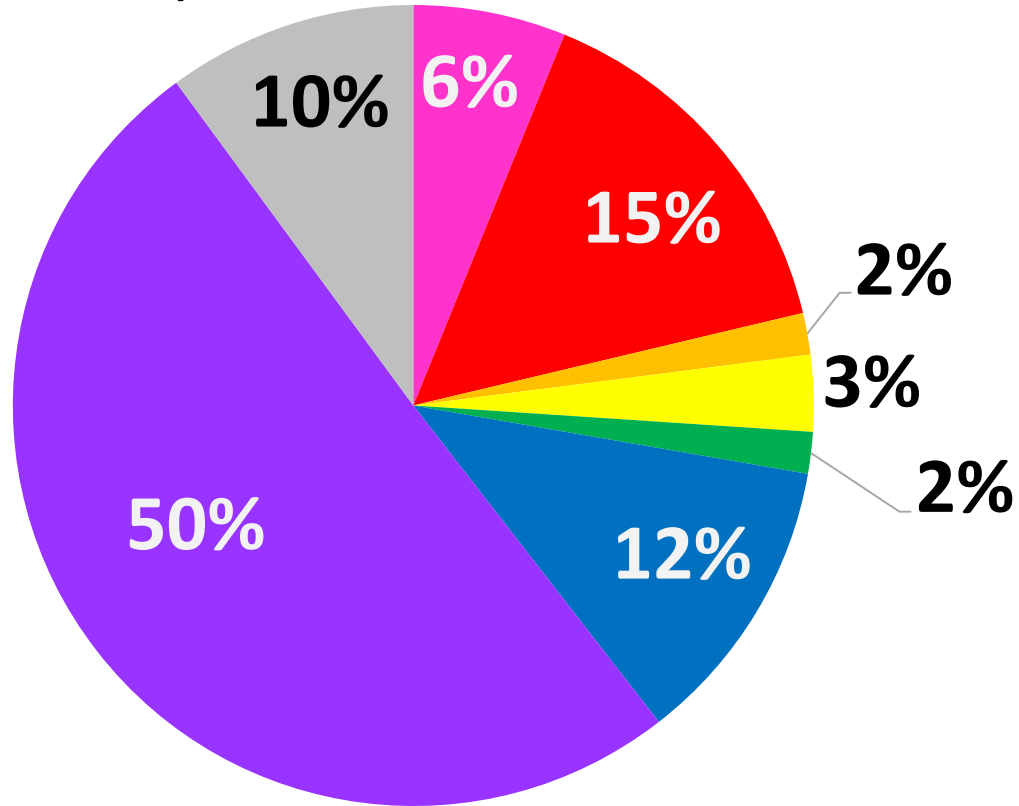
Patient Demographics for Rapid HCV Testing, 2019



Source: DDP, Hepatitis Testing Database, 8/24/2020

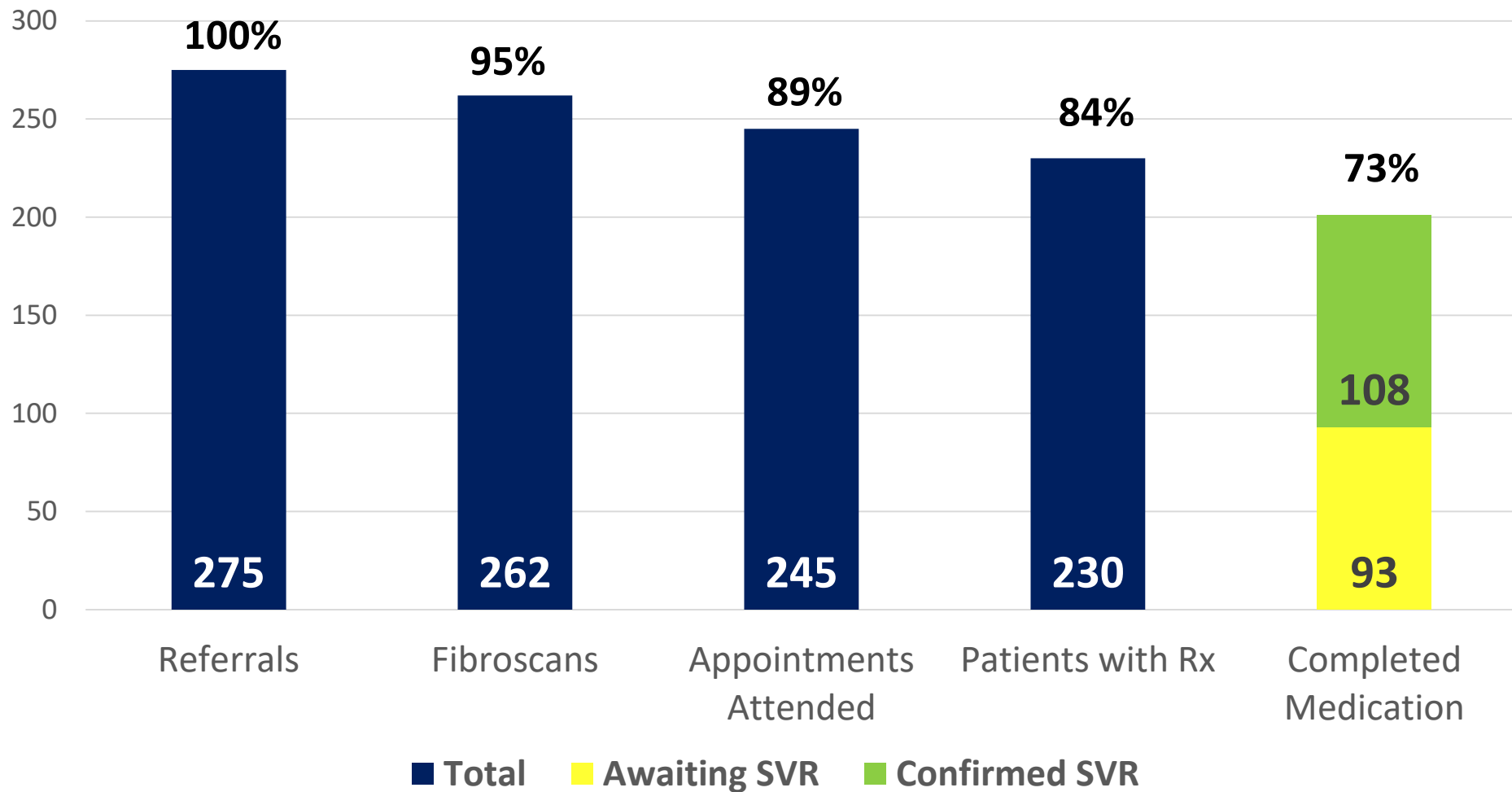
Common Reported Risk for Persons with Positive Rapid Test, 2019

- All three (IDU, Incarceration, Birth Cohort)
- IDU Only
- IDU and Birth Cohort
- Birth Cohort Only
- Birth Cohort and Incarceration
- Incarceration Only
- IDU and Incarceration
- Other or No Reported Risk



Source: DDP, Hepatitis Testing Database, 8/24/2020

Hepatitis C Treatment Pilot Care Cascade





Hepatitis C Treatment Guidelines: The why and how of integrating them into your practice.

Rebecca Dillingham, MD/MPH

Associate Professor of Medicine

University of Virginia Division of Infectious Disease and International
Health

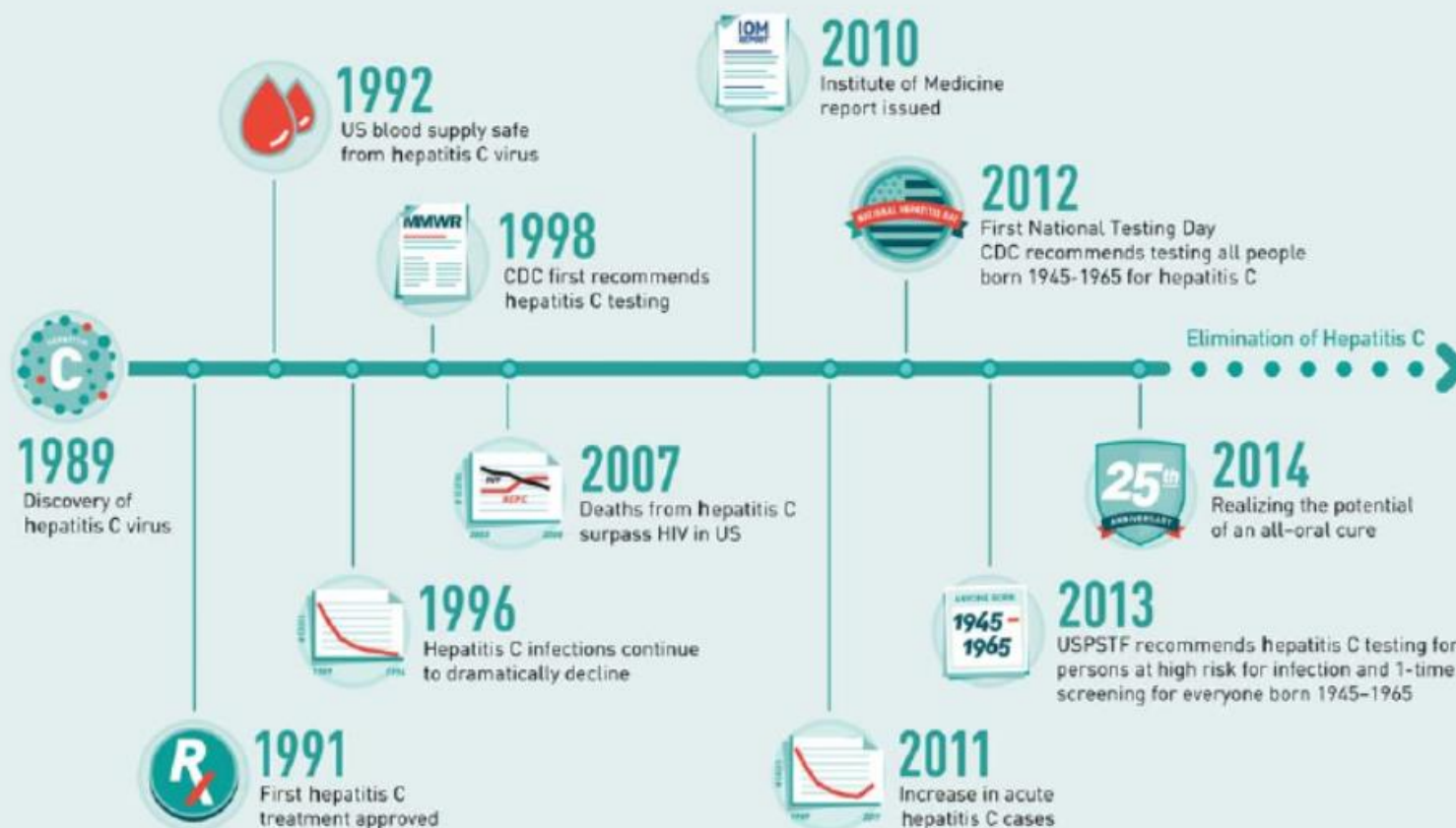


Dr. Dillingham has received an investigator-initiated grant from Gilead. She also serves as a consultant to Warm Health Technologies, Inc, an mHealth company.



25 Years Since Discovery—A Timeline of Major Milestones

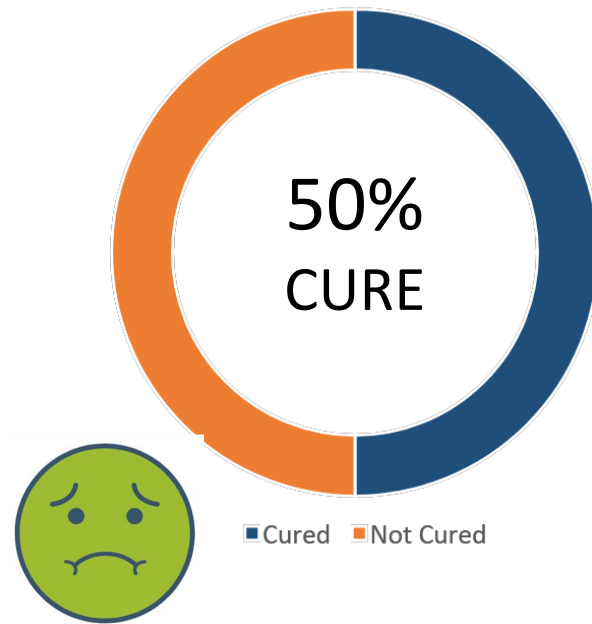
HEPATITIS **C** 25 YEARS



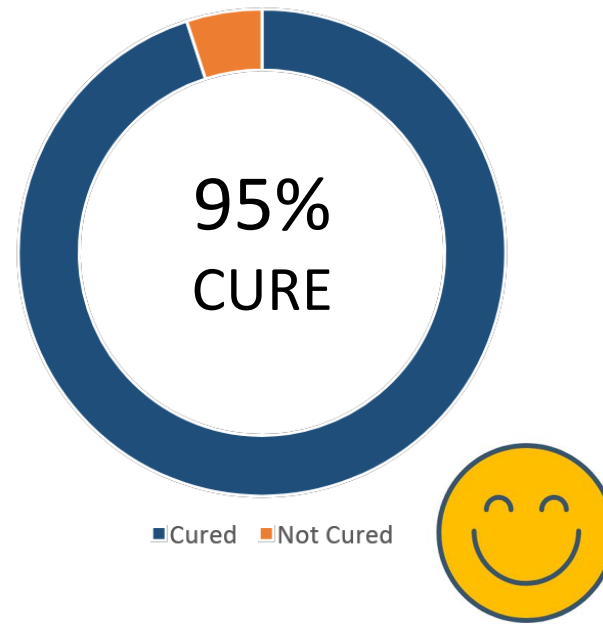
<https://aasldpubs.onlinelibrary.wiley.com/doi/epdf/10.1002/hep.27377>

Hepatitis C Treatment 2010-2020

Interferon-Based Regimens



Direct Acting Antivirals





HCV Guidance: Recommendations for
Testing, Managing, and Treating
Hepatitis C



Home

Test, Evaluate, Monitor

Treatment-Naive

Treatment-Experienced

Unique & Key Populations

About



New and updated:

[Updated Testing
Recommendations](#)

Review new HCV screening
guidance from the AASLD and IDSA.

Start Here: Choose a patient profile from the menu above. ↑



Welcome to HCVGuidelines.org

The AASLD and IDSA in partnership with the panel have created an updated web experience to facilitate easier and faster access to this important resource. Please select a patient profile from the menu above, click on a guidance section below, or use the search box to begin.



Contents and Introduction - *Select a Page*



Testing, Evaluation, and Monitoring of Hepatitis C - *Browse Topics*

April 2020!!

Recommendations for One-Time Hepatitis C Testing

RECOMMENDED

RATING ⓘ

One-time, routine, opt out HCV testing is recommended for all individuals aged 18 years or older.

I, B

One-time HCV testing should be performed for all persons less than 18 years old with activities, exposures, or conditions or circumstances associated with an increased risk of HCV infection (see below).

I, B

Prenatal HCV testing as part of routine prenatal care is recommended with each pregnancy.

I, B


Periodic repeat HCV testing should be offered to all persons with activities, exposures, or conditions or circumstances associated with an increased risk of HCV exposure (see below).

IIa, C

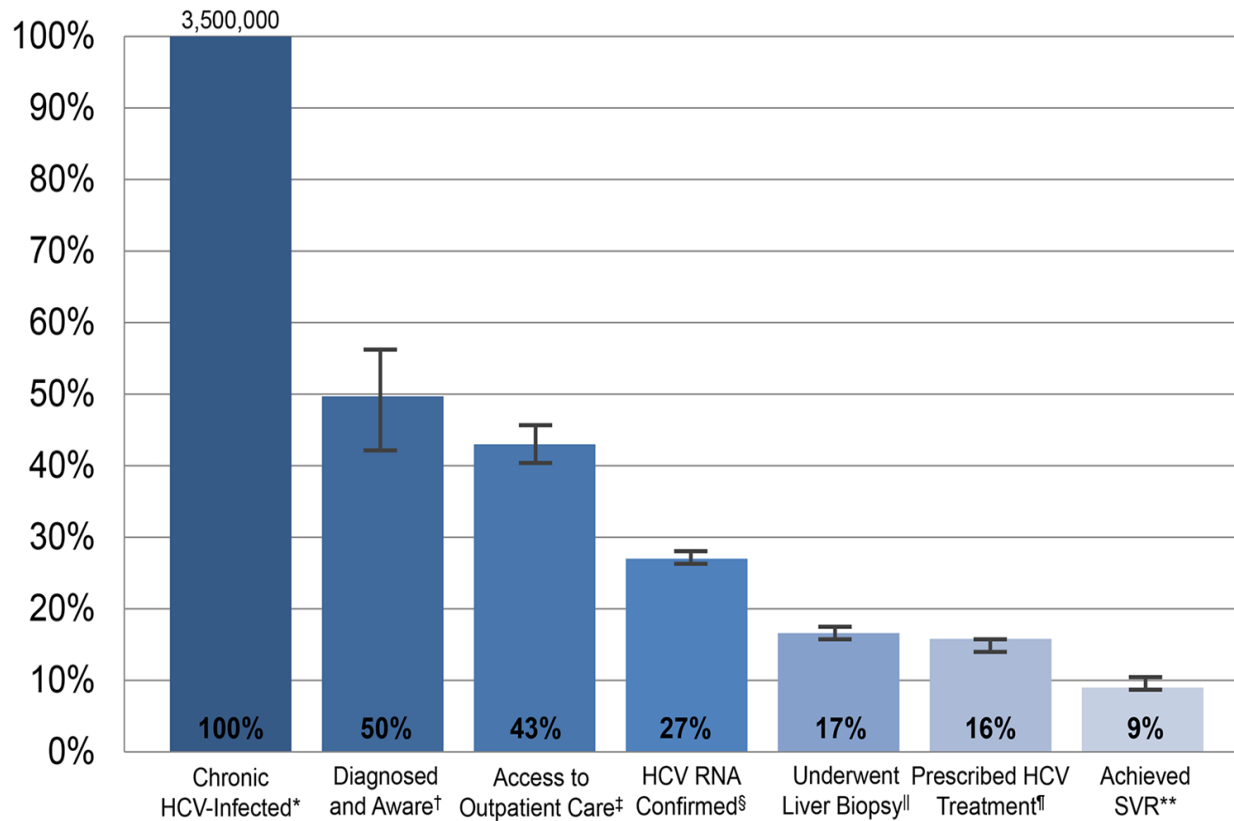
Annual HCV testing is recommended for all persons who inject drugs, for HIV-infected men who have unprotected sex with men, and men who have sex with men taking pre-exposure prophylaxis (PrEP).

IIa, C

Recommendations for Counseling Persons With Active HCV Infection

RECOMMENDED	RATING 
Persons with current HCV infection should receive education and interventions aimed at reducing liver disease progression and preventing HCV transmission.	IIa, B
Abstinence from alcohol and, when appropriate, interventions to facilitate cessation of alcohol consumption should be advised for all persons with HCV infection.	IIa, B
Evaluation for other conditions that may accelerate liver fibrosis, including hepatitis B and HIV infections, is recommended for all persons with active HCV infection.	IIb, B
Evaluation for advanced fibrosis using noninvasive tests (serum panels, elastography) or liver biopsy, if required, is recommended for all persons with HCV infection to facilitate an appropriate decision regarding HCV treatment strategy, and to determine the need for initiating additional measures for cirrhosis management (eg, hepatocellular carcinoma screening) (see Monitoring section).	I, A
Vaccination against hepatitis A and hepatitis B is recommended for all susceptible persons with HCV infection.	IIa, C
Vaccination against pneumococcal infection is recommended for all patients with cirrhosis.	IIa, C
All persons with HCV infection should be provided education about how to prevent HCV transmission to others.	I, C

Cascade of Care



SVR = Sustained Virologic Response = "Cure"

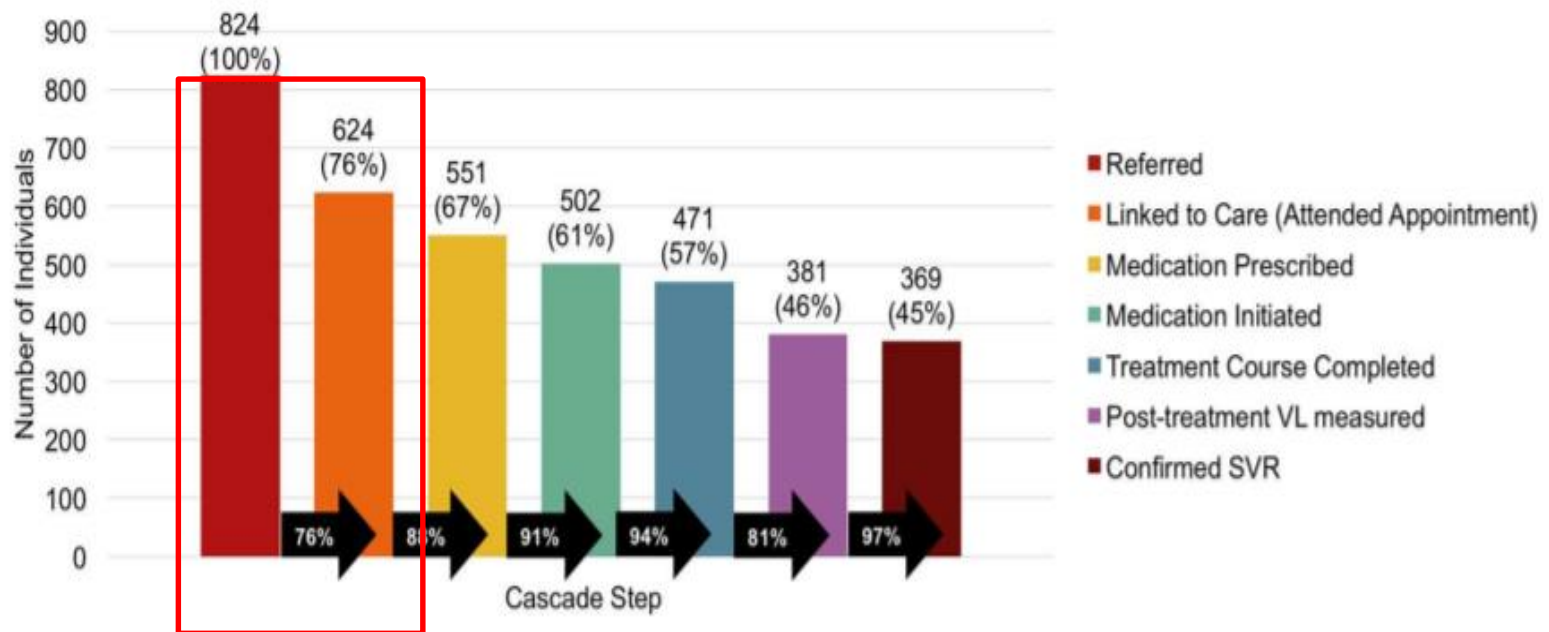


FIGURE 1 | Hepatitis C cascade of care. VL, viral load; SVR, sustained virologic response.

Sherbuk et al. *Front Public Health*.
2019;7:362. Published 2019 Nov 27.
doi:10.3389/fpubh.2019.00362

Reason	N	%
Multiple no-shows despite scheduled appointments	53	26.5%
Unable to contact to schedule an appointment	41	20.5%
No reason documented	24	12.0%
Incarcerated	20	10.0%
Patient Preference	19	9.5%
Referred/Treated Elsewhere	16	8.0%
Moved Out of Area	10	5.0%
Deceased	5	2.5%
Pregnant	4	2.0%
Spontaneous Viral Clearance	4	2.0%
Other ^a	4	2.0%

Data obtained from clinic database maintained by nurse coordinator.

^a "Other" includes lack of transportation (1), work conflict with clinic schedule (1), initial visit scheduled and upcoming (1), deferred due to upcoming surgery (1).

Sherbuk et al. *Front Public Health*. 2019;7:362. Published 2019 Nov 27. doi:10.3389/fpubh.2019.00362

Major Themes	Proposed Interventions to Improve Care
Structural Barriers: Financial, Scheduling, Transportation, Health-system level	Expand Medicaid ; Utilize pharmaceutical company drug assistance programs; Educate patients on available resources and supportive care; Aim for clinic responsiveness, ease of scheduling, and confidentiality
Stigma	Provide education on harm reduction strategies; Co-locate treatment for substance use disorder and HCV ; Educate clinic staff on creating a welcoming atmosphere
Ambivalence	Acknowledge and address the uncertainty related to having HCV; Focus patient education campaigns on ambivalence and the potential for treatment to relieve patients of the burden of uncertainty
Prior Experiences of HCV Disease and Treatment	Explore patients' or others' prior experiences with HCV treatment; Address favorable changes in treatment since earlier therapies
Patient-Provider Relationship	Encourage expansion of HCV treatment to where patients are already receiving care and have established relationships Sherbuk et al. Harm Red J. In press.

TELEMEDICINE CONNECTION PROGRAM



UVA ID Specialist



Will see your patients in
your clinic via telehealth



Specialty Pharmacy will assist
in obtaining patient meds

HEPC TRAINING PROGRAM



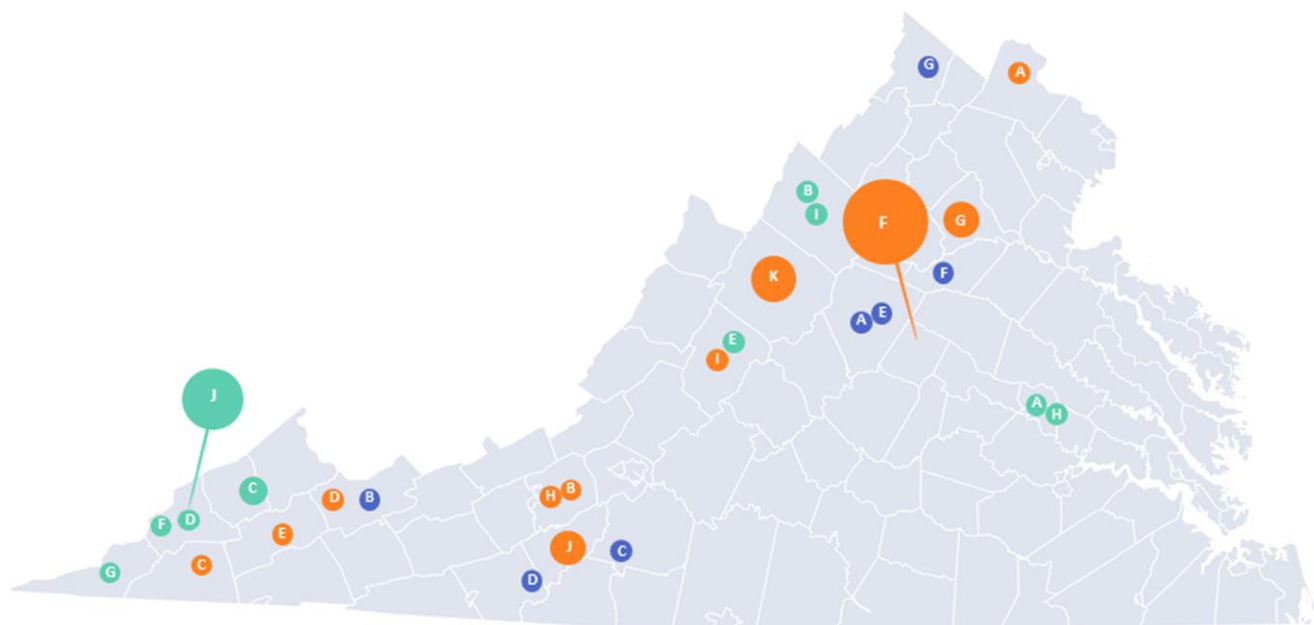
Each quarter HEPC holds
a training day where LIPs
learn to treat HCV
independently



Prior to the training day HEPC
will assist in getting your clinic
ready to implement a hepatitis C
treatment program



After training, your clinic will have
access to UVA ID consultation and
staff to assist with the process
and to obtain medication



+	●	June 2019
1	A	Department of Corrections, Richmond
	B	Rockingham Harrisonburg Health Dept.
	C	Stone Mountain Health, Haysi
	D	Hopkins Medical Association
	E	Lexington Health Dept
	F	Norton Community Hospital
	G	Stone Mountain Health, St. Charles
	H	VCU MOTIVATE
	I	Waynesboro Health Dept
39	J	Wise Health Dept.

Conference held in Staunton

+	●	September 2019
	A	Adams Compassionate Health Network
	B	CHC NRV
	C	Clinch River Health Services
	D	Cumberland Mountain Community
	E	Cumberland Plateau Health Dept
132	F	Department of Corrections, Troy
3	G	Free Clinic of Culpeper
	H	Montgomery County HD
	I	Rockbridge Area Health Center
2	J	Tri Area Health Care, Floyd
7	K	Valley Community Services Board

Conference held in Charlottesville

+	●	December 2019
	A	Addiction Allies OPTIONS
	B	SWVA Community Health Systems
	C	TriArea Health Care, Ferrum
	D	TriArea Health Care, Laurel Fork
	E	UVA
3	F	UVA Orange PCP
3	G	Valley Health Winchester

Conference held in Charlottesville

**Past HEPC
trainees and
patients treated**

⊕ = patients treated

HEPC TRAINING PROGRAM



Each quarter HEPC holds a training day where LIPs learn to treat HCV independently

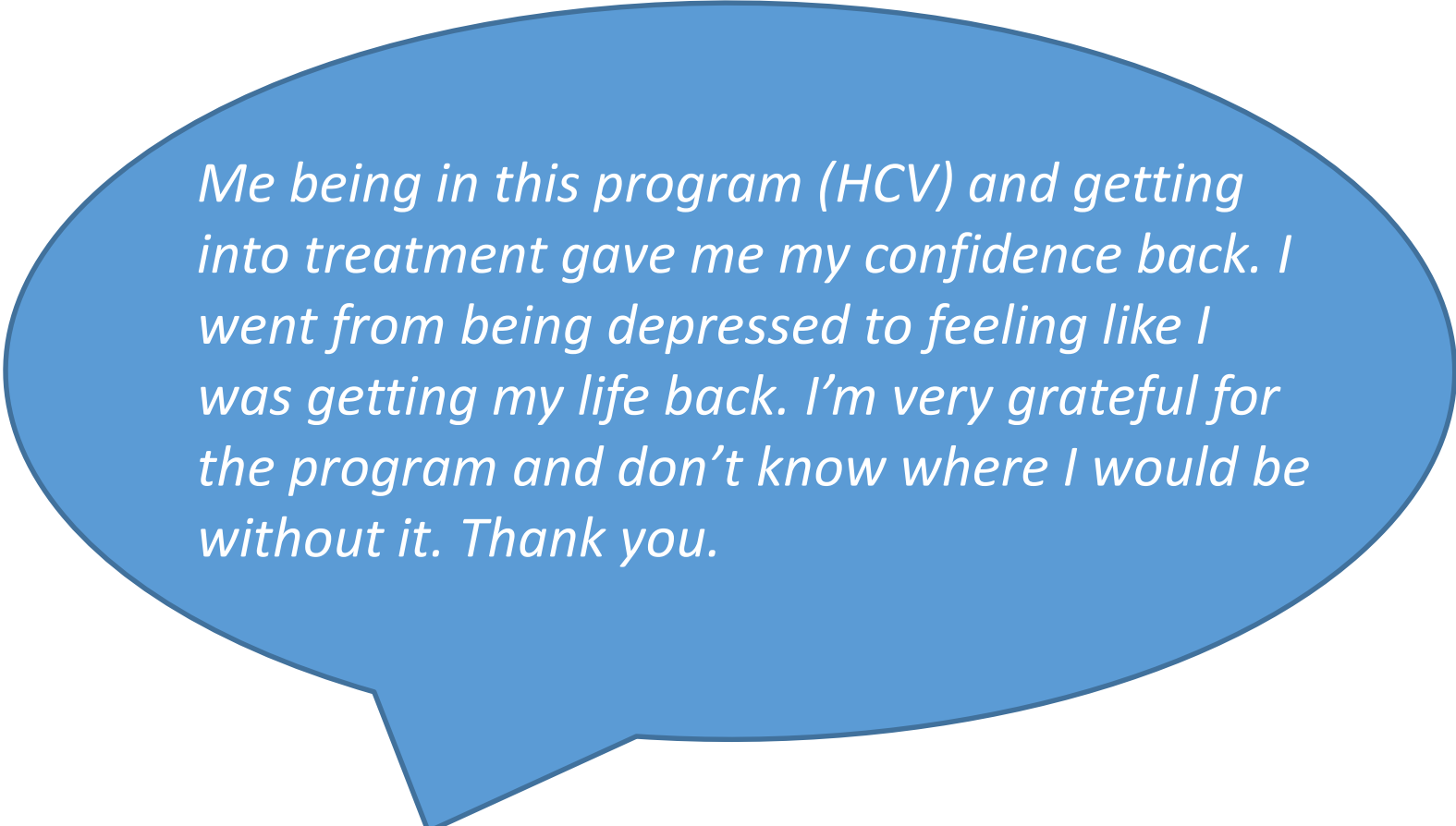


Prior to the training day HEPC will assist in getting your clinic ready to implement a hepatitis C treatment program



After training, your clinic will have access to UVA ID consultation and staff to assist with the process and to obtain medication

- Moving to on-line separated into several sessions
- CE credits available
- No cost to participants
- Follow-up ECHO program monthly
- ***Brings the guidelines to life and provides practical steps for integrating them into your practice***



Me being in this program (HCV) and getting into treatment gave me my confidence back. I went from being depressed to feeling like I was getting my life back. I'm very grateful for the program and don't know where I would be without it. Thank you.

Interrupted HCV Treatment Courses: Cases and Lessons From the National Clinician Consultation Center (NCCC) HEPline

Cristina Gruta, PharmD

Senior Consultant/Clinical Pharmacist

National Clinician Consultation Center



CLINICIAN-TO-CLINICIAN ADVICE

Objectives

- Explain the role the HCV Warmline (HEPline) can play in providing clinical support to HCV providers
- Discuss the different types of HCV treatment lapse scenarios
- Describe factors that lead to interruptions in HCV treatment
- Discuss pre-emptive or real-time interventions that HCV treaters can make to avoid or minimize treatment interruptions

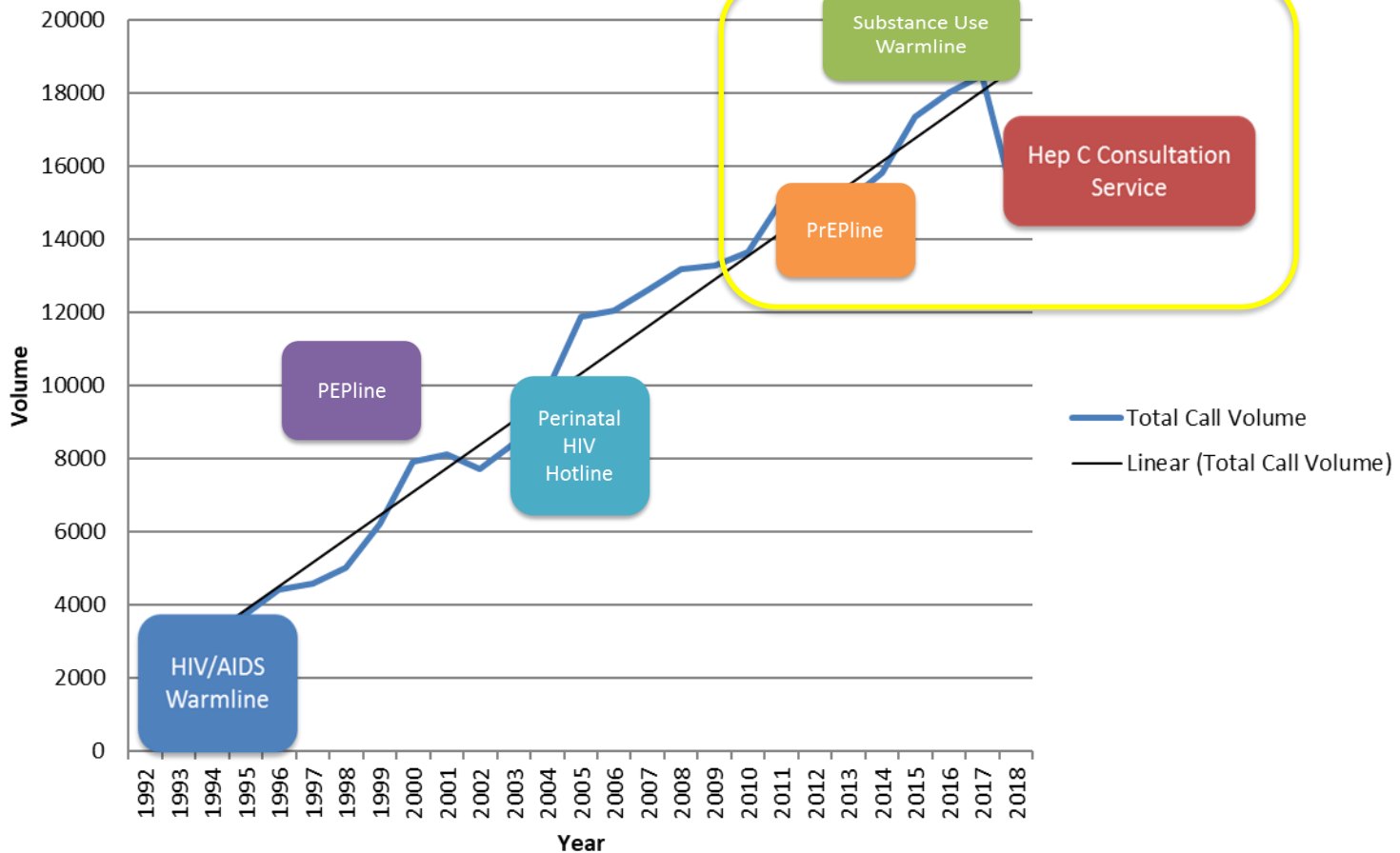


NATIONAL CLINICIAN
CONSULTATION CENTER

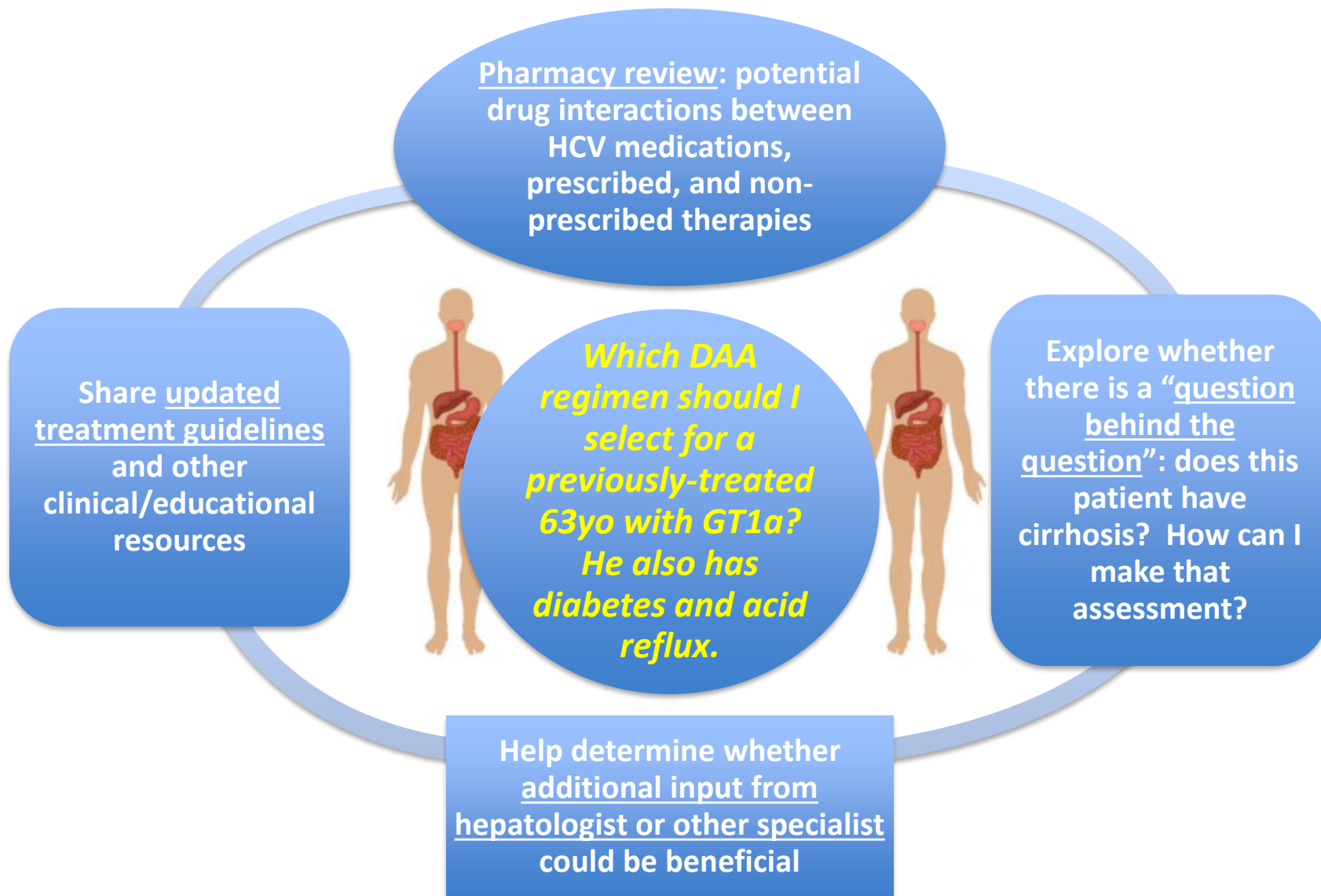
Translating science into care

What does the NCCC do?

Call Volume (by service-line), 1992-2018



“Anatomy” of a HEPline Consultation





NATIONAL CLINICIAN
CONSULTATION CENTER

Translating science into care

Wide range of case topics

My patient's HCV antibody test just came back positive and she is 5 months pregnant. What should I do?

I'm not sure if my patient has cirrhosis: what regimen should I select and how many weeks of treatment do I give?

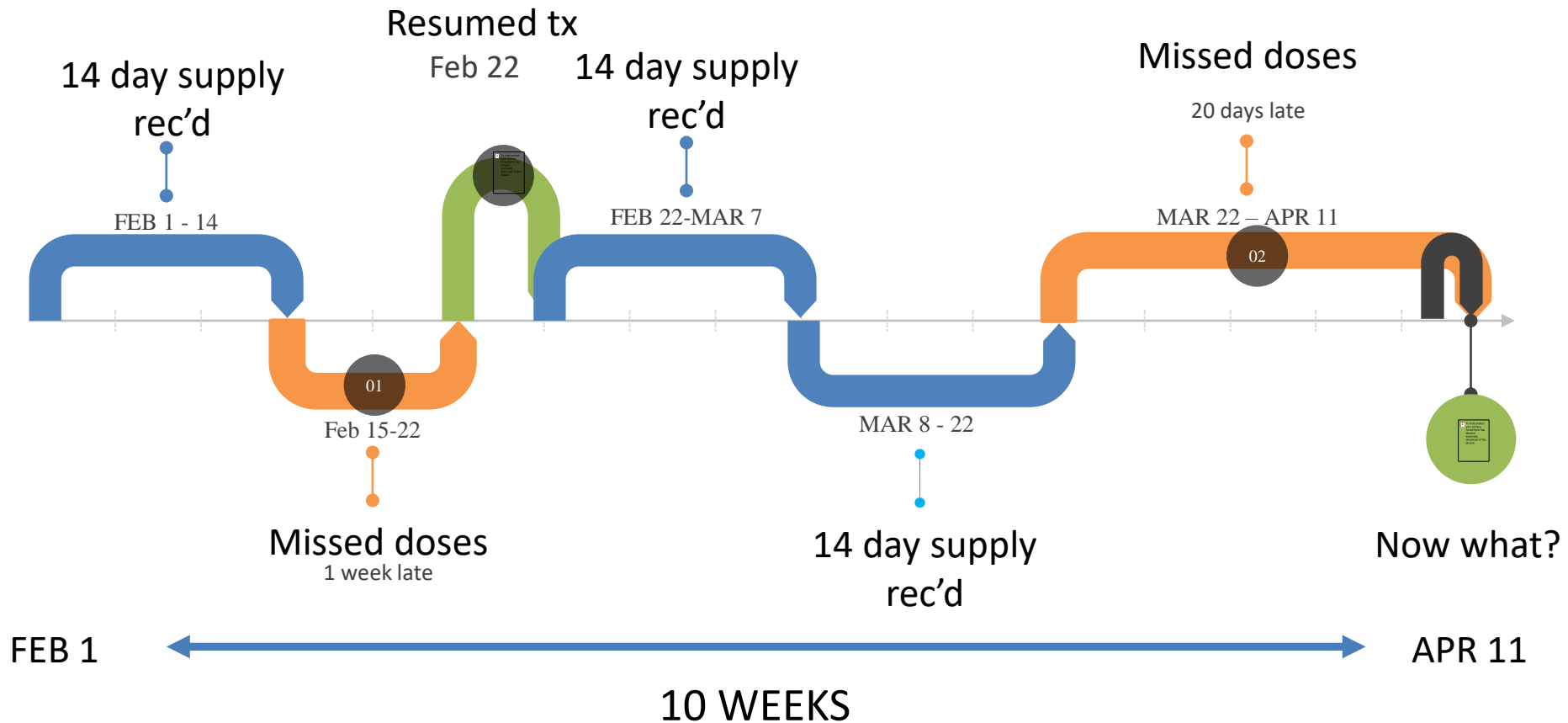
My patient has HBV serologies of someone with recovered infection (HBsAb+, HBcAb+). How should I follow them once we start DAA treatment?

Can the HCV Warmline team serve as the "consulting specialist" since my state's insurance program requires review by a specialist?

HEPline: Case “A”

- Caller is NP in Northern California FQHC → not the pt’s PCP but is the HCV “treater” in the clinic
- Pt is 28 yo male with GT 1a infection, tx-naïve; VL 94,230; FIB-4 → 0.92
- Pt still actively using IV drugs
- Decision was to tx pt with GLE/PIB x 8 weeks starting Feb 2019
- Caller saw pt in urgent care in mid-March 2019 (for non-HCV related reasons) and at that visit reported missed doses of G/P
- Pt reportedly went to rehab sometime in late March/early April– missed G/P doses x 1 week

Case “A” – Treatment interruption timeline



QUESTION → What is best approach?

What our consultation data showed

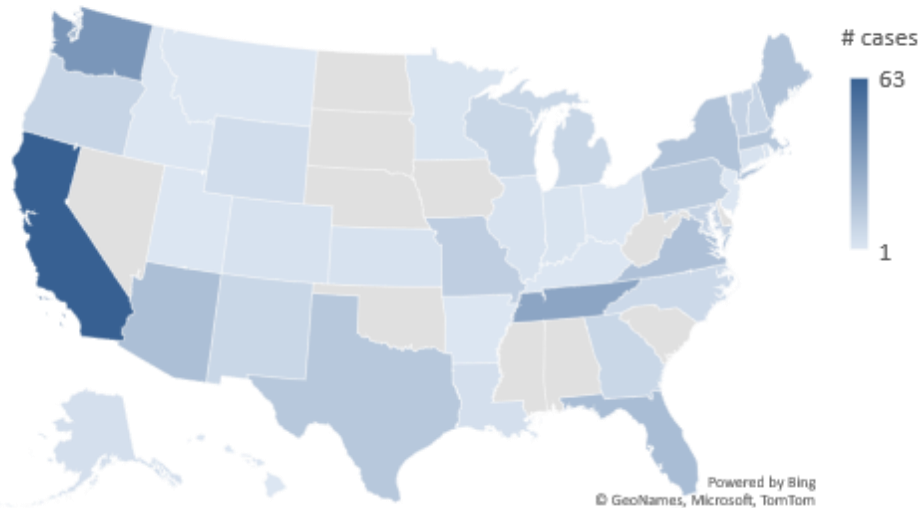
- Reviewed HEPLine calls 11/1/18 through 4/30/20
- Identified calls that pertained to interrupted or lapsed HCV treatment
- Excluded calls if not patient-specific, i.e. posing general question
- Excluded calls involving pregnant patients
- Collected both caller and patient demographics
- Identified situational themes for the context of interruptions



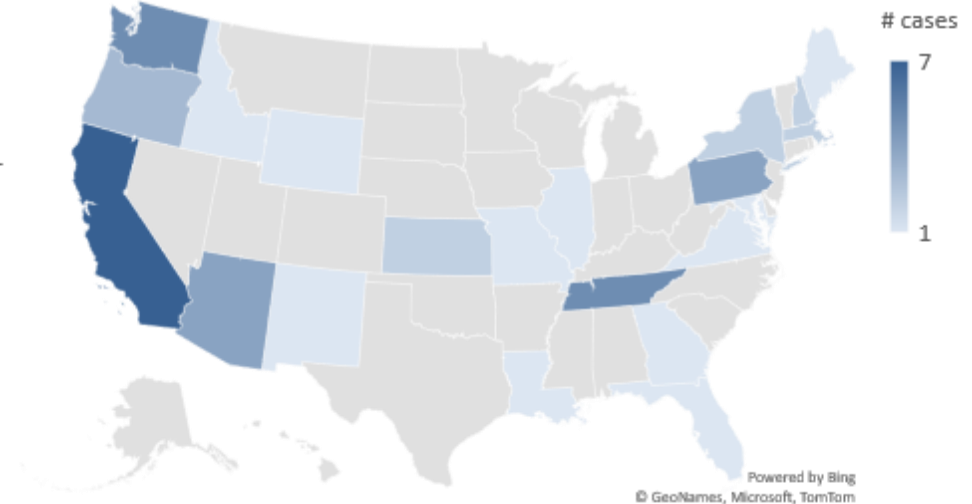
NATIONAL CLINICIAN
CONSULTATION CENTER
Translating science into care

Number of cases reviewed

Cases by state N = 395

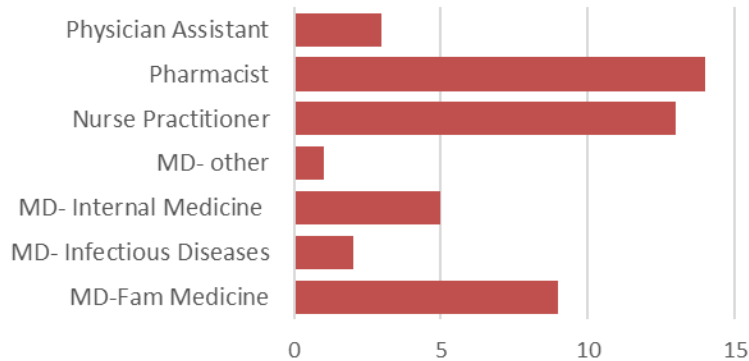


Cases with lapsed treatment
N=47

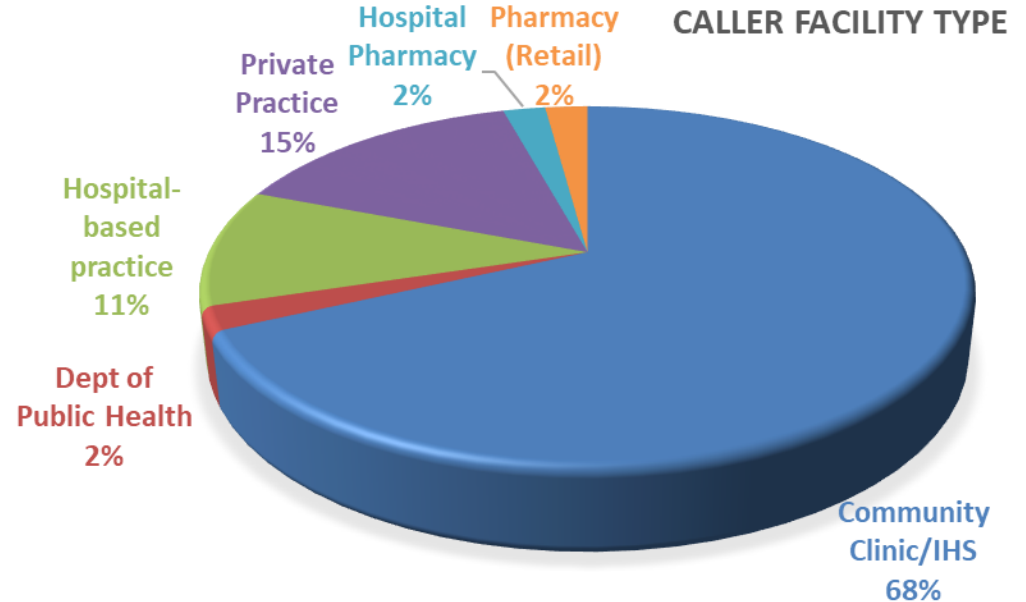
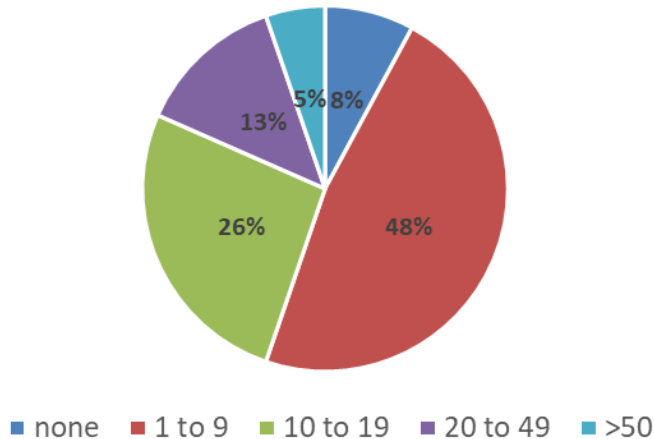


Caller demographics

Caller Profession



PATIENT LOAD/MONTH

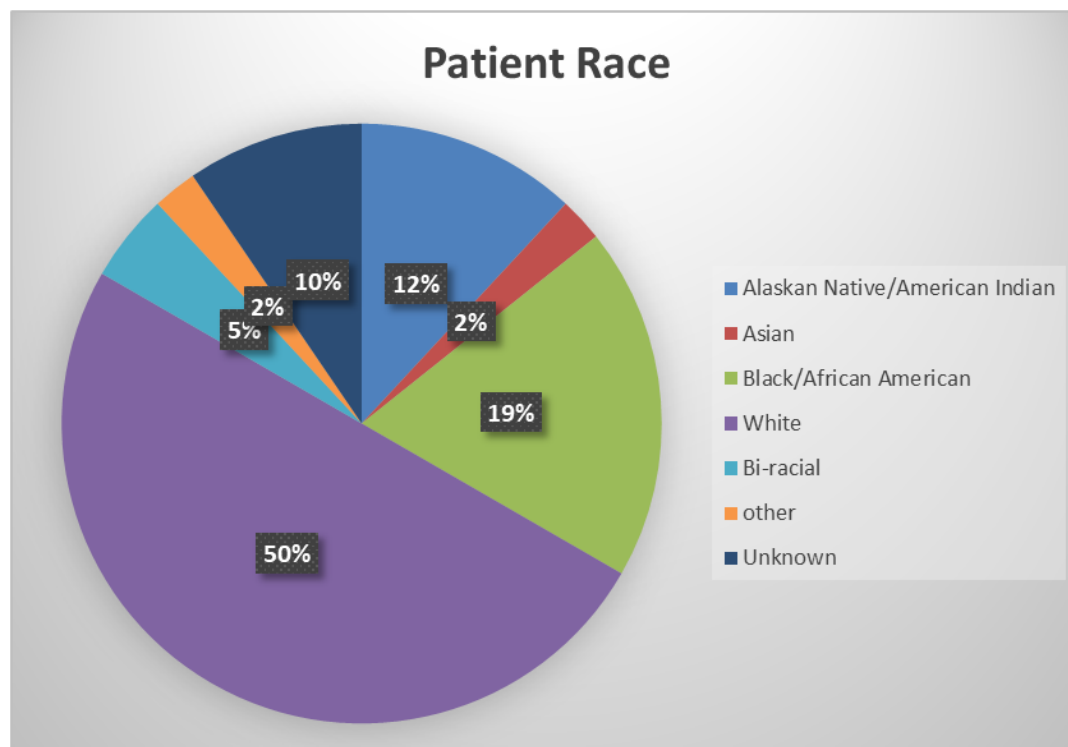


Years HCV Experience	
range	<1 to 25
average	3.25
median	1.50

Patient demographics

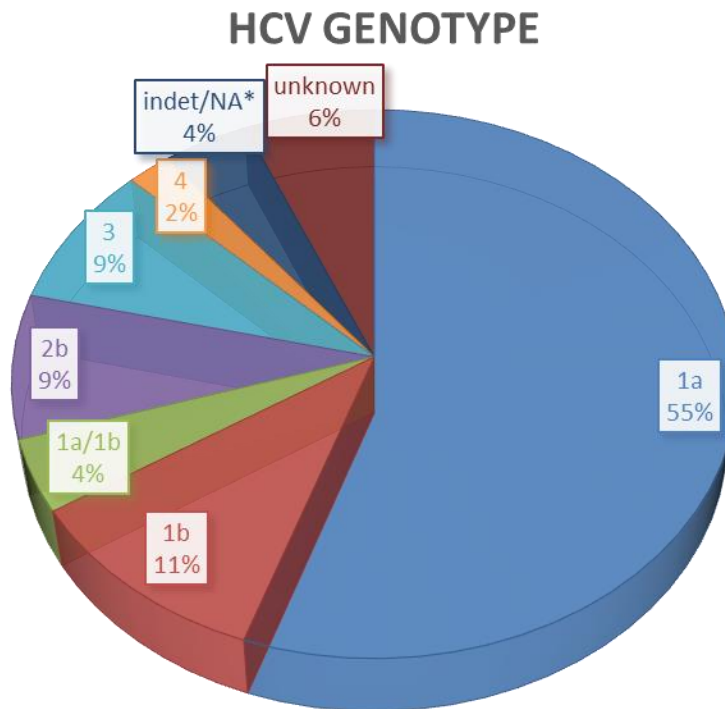
Patient Gender	
Female	15
Male	31
DNA/NA	1

Patient Age	Years
Range	23-70
Average	47.068
Median	48

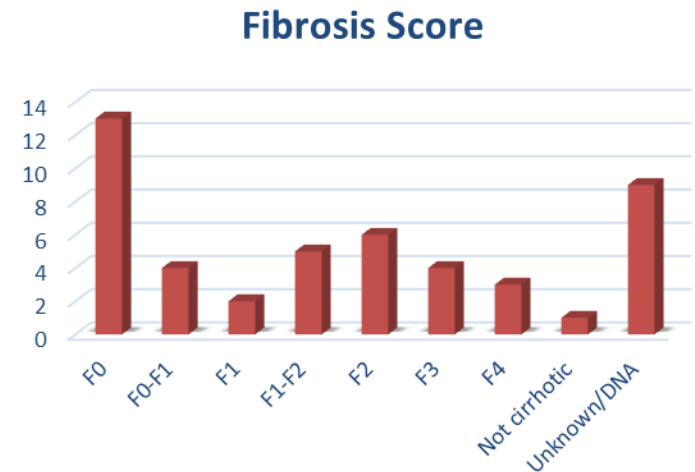


Patient HCV characteristics

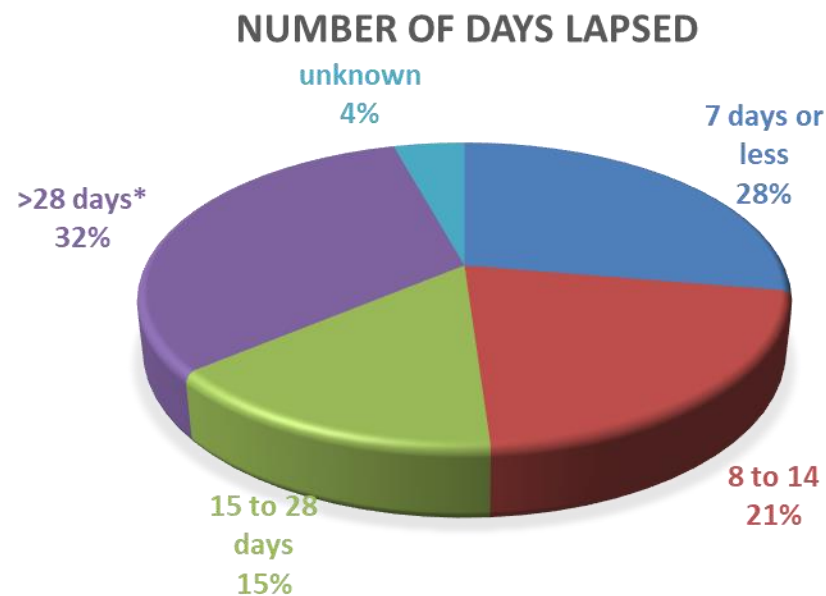
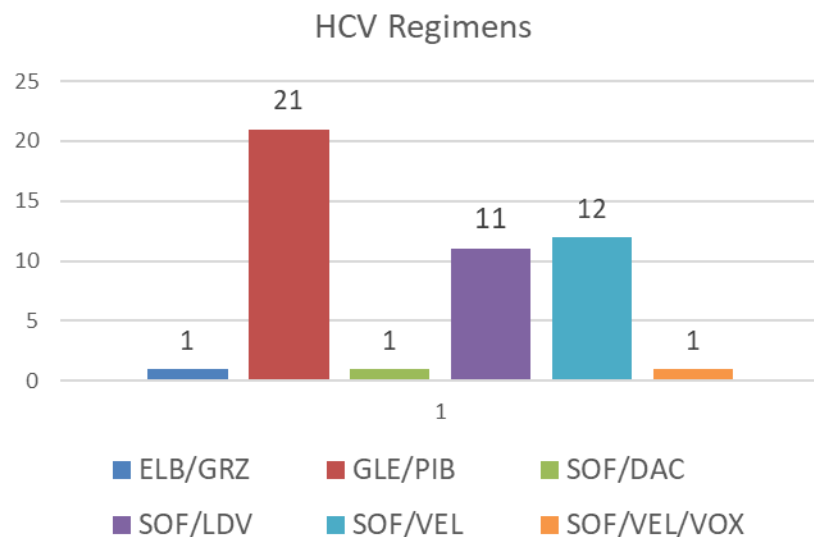
Tx Naïve or Experienced	
Experienced	3
Naïve	42
Unknown	2



*For "indet/NA" category, genotyping not covered by HCV treatment funds



HCV treatment course selection



*For >28 days lapsed, range >4 weeks to 2 years

WHAT LEVEL OF ADHERENCE TO DAA TREATMENT IS NEEDED TO ACHIEVE SVR12?



ANCHOR: pilot study of HCV treatment at drop-in harm reduction organization in Washington, DC

- Single-center study
 - 76% men, 93% black, 33% cirrhotic, 58% injected drugs at least daily, 33% receiving medication-assisted therapy for drug use

Patients with chronic HCV infection, opioid use disorder, and opioid injection in last 3 mos; no decompensated cirrhosis or contraindicated DDIs
(N = 100)



SOF/VEL* QD

Concurrent buprenorphine and HIV PrEP offered as indicated

*Dispensed in 28-day increments at Day 1, Wk 4, Wk 8 (ie, 3 bottles).

- Primary endpoint: SVR12

ANCHOR: HCV treatment at harm reduction organization

- 93 patients in ITT analysis
 - Lost to follow-up: n = 8
 - Deceased: n = 3
 - Virologic failure: n = 9
 - **SVR12: n = 73 (78%)**
- Per protocol SVR12: 89% (73/82)
- Virologic success unaffected by baseline demographics such as drug use frequency, housing stability, medication-assisted therapy

Adherence Measure in ITT Population		SVR12, %	P Value
Wk 4 HCV RNA < 200 IU/mL	<ul style="list-style-type: none"> ▪ Yes (n = 80) ▪ No (n = 8) 	86 25	.0005
No treatment interruptions	<ul style="list-style-type: none"> ▪ Yes (n = 76) ▪ No (n = 12) 	86 67	.22
Completed 2 or 3 of 3 SOF/VEL bottles	<ul style="list-style-type: none"> ▪ Yes (n = 87) ▪ No (n = 6) 	84 0	.0001
Finished SOF/VEL on time (vs late)	<ul style="list-style-type: none"> ▪ Yes (n = 20) ▪ No (n = 43) 	95 88	.65

ANCHOR study– additional observations

- 59 pts completed 12 weeks of treatment but not all on time

Number (%) of pts completing 12 week course	# days completed beyond expected completion date
28 (48%)	1-7
9 (16%)	8-14
9 (16%)	>14

- Of 58 pts who reached week 24 follow-up, 52 (90%) attained SVR

What are the limits of imperfect adherence?

- Studies are small
- Show encouraging success if SOF/VEL regimen completed 1-2 weeks beyond intended end-of-treatment
- Do other DAA options offer similar forgiveness?
- But what about those who miss more than 1-2 weeks of treatment?

HCV treatment lapse- multiple types of scenarios

My patient didn't know to call the pharmacy to refill his SOF/VEL and it's been 10 days. Is it okay to continue?

A new patient to us says they took a month of SOF/LDV a year ago but stopped. Now they are ready to be treated. Should we start over or give rescue therapy?

Our patient received her first month of HCV treatment, started using meth again and was LTFU. Now she is back after a 3 week lapse. Do we stop?



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WHAT CIRCUMSTANCES LEAD TO TREATMENT GAPS?

Reported reasons for lapses (HEPline cases)

<u>OVERALL</u>	
Unknown	10
Lost to follow-Up	2
Substance involvement/relapse	9
Unstable housing/homelessness	2
Pharmacy Issues (delivery)	5
Patient confusion- med access	5
Incarceration	3
Insurance lapse/issues	2
Patient could not get to clinic	3
Patient acutely sick/hospitalized	6
Adverse effect (suspected)	3
Clinic miscommunication	1
Immigration from other country	1
Patient adherence issues/forgets	2

Most common identified reasons:

- 1) Substance involvement/relapse
- 2) Medication access issues
 - Pick-up confusion
 - Lost deliveries
 - Insurance lapses/issues
- 3) Acute illness or exacerbated chronic illness



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TREATING HCV IN PRIMARY CARE SETTING: MODELS OF CARE

HCV in primary care settings

> Infect Dis (Auckl). 2019 Apr 28;12:1178633719841381. doi: 10.1177/1178633719841381.
eCollection 2019.

Integration of Hepatitis C Treatment in a Primary Care Federally Qualified Health Center; Philadelphia, Pennsylvania, 2015–2017

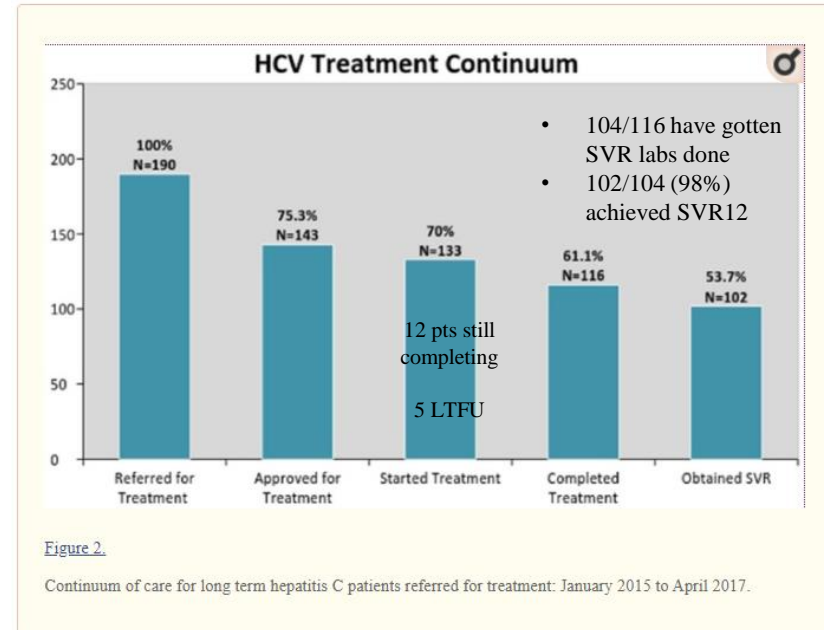
Tyler S Bartholomew^{1 2}, Kaitlin Grosgebauer², Katherine Huynh³, Travis Cos^{3 4}

Affiliations + expand

PMID: 31065216 PMCID: PMC6488784 DOI: 10.1177/1178633719841381

[Free PMC article](#)

- FQHC in Philadelphia with high burden of underserved population with high rates of mental illness and/or substance involvement
- HCV treatment team lead by physician assistants and NPs (supervised by 2 PCPs) but no onsite GI/hepatologist
- Rest of team included
 - Behavioral health consultants (BHCs)
 - HCV treatment coordinator
 - 340B pharmacy which processes prior authorizations, assess for drug interactions, provides medication refills



CONCLUSION:

“With the proper support and integrated BHCs, treating HCV in a primary care setting with high rates of substance abuse and mental health illness is possible and effective.”

Pharmacist role in HCV treatment

> J Prim Care Community Health. Jan-Dec 2018;9:2150132718807520.
doi: 10.1177/2150132718807520.

A Regional Analysis of Hepatitis C Virus Collaborative Care With Pharmacists in Indian Health Service Facilities

Rebecca Geiger¹, Jessica Steinert², Grant McElwee³, Jennifer Carver⁴, Robert Montanez⁵, Julie Niewoehner⁶, Cassandra Clark⁷, Brigg Reilley⁸

Affiliations + expand

PMID: 30348039 PMCID: PMC6201170 DOI: 10.1177/2150132718807520

[Free PMC article](#)

“These data indicate that rural clinics using collaborative practice agreements with pharmacists can be instrumental in HCV services at the primary care level and have strong outcomes in HCV treatment/SVR12. ”

- IHS facilities treated pts with HCV using pharmacists as point of contact
- Utilized collaborative practice agreement and HCV telehealth to external specialists
- Pharmacists provide comprehensive HCV care under MD supervision
- Analysis of collaborative practice looked at charts for proportion of pts with HCV Ab status, confirmatory testing, liver staging, treatment and SVR rate.
- Biggest gap was step between staging and initiation of treatment
- Concluded feasibility of treating HCV in rural settings

Patient navigation

> Clin Infect Dis. 2017 Mar 1;64(5):685-691. doi: 10.1093/cid/ciw806. Epub 2016 Dec 10.

From Care to Cure: Demonstrating a Model of Clinic-¹ Patient Navigation for Hepatitis C Care and Treatment in High-Need Patients

Mary M Ford ¹, Nirah Johnson ¹, Payal Desai ¹, Eric Rude ¹, Fabienne Laraque ¹

Affiliations + expand

PMID: 27940945 DOI: 10.1093/cid/ciw806

- Check Hep C → NYC DOHMH patient navigation program
- Program based in either FQHCs (where care was “onsite”) or harm reduction/needle exchanges (pts linked to “offsite providers”)
- Patient navigators provided risk assessment, health education, treatment readiness and medication adherence counseling, and medication coordination

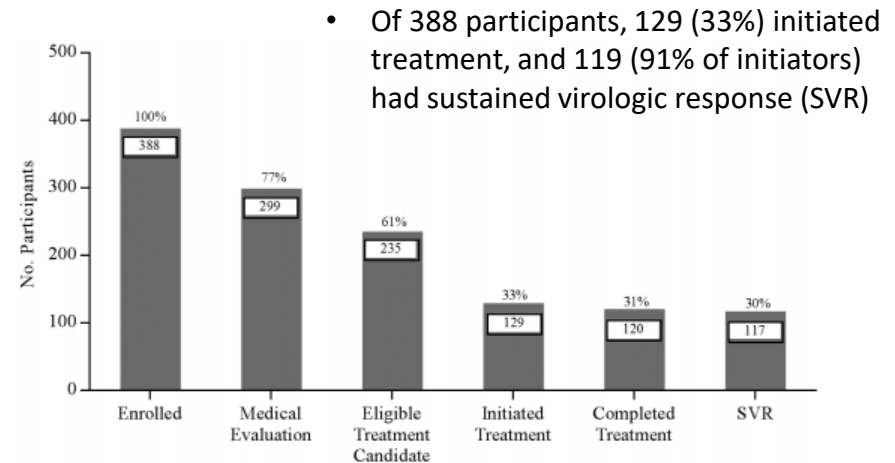


Figure 1. Check Hep C program hepatitis C virus care continuum. Abbreviation: SVR, sustained virologic response.

CONCLUSION- Check Hep C successfully supported high-need participants through HCV care and treatment, and SVR rates demonstrate the real-world ability of achieving high cure rates using patient navigation care models.



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LESSONS LEARNED- HOW DO WE PREVENT HCV TREATMENT GAPS?

Preventing HCV treatment lapses/gaps-

Patient factors

- Motivation/readiness
 - Educate about health benefits and prevention of forward transmission
 - No need to be abstinent to be treated
- If ready, do they have ready access to
 - Insurance coverage and if not special programs
 - Medical visits, including specialist access if HCV treatment not done in primary care
 - Labs/pharmacy
- Are there co-occurring issues/social determinants that may potentially affect adherence?
 - Housing/place to store meds safely
 - Transportation
 - Substance involvement– where are they with this?
- Patient understanding of medication regimen before and during treatment
 - Dosing/administration/side effects/consequences of suboptimal adherence
 - When/how to pick up meds or setting up delivery at appropriate timeframe
 - How to communicate with clinic staff



Preventing HCV treatment lapses/gaps- Medical system factors

- Structure of HCV treatment team (other than the provider)
 - Who coordinates care? Is there HCV panel management?
 - Does community have HCV patient navigation program?
 - What is the system for reminding patients of visits, labs, pharmacy pickups?
 - Who takes care of prior authorizations or insurance issues?
- Addressing patient's substance involvement and mental health needs
 - Are social services and mental/behavioral health support available?
 - Is MAT co-located in clinic or coordinated with another clinic?
 - Is HIV PrEP offered for those with ongoing risk?
- Optimize communications with the patient, the pharmacy, within the clinic
 - What is follow-up protocol (phone calls, in-person visit, labs)?
 - What is best mode of communication with pt– text, phone, email, EMR portal



Preventing HCV treatment lapses/gaps- Pharmacy factors

- How comfortable is patient/clinic with chosen pharmacy?
- Does the pharmacy have reliable patient reminder systems?
- Does pharmacy contact prescriber for missed prescription pick-ups?
- What is role of specialty pharmacies if available?
 - May be able to do prior authorizations
 - Should have specialized pharmacists/staff with HCV training
 - 340B pricing?
- Dispensing of 14-day vs 28-day supplies of HCV regimen
 - Is it better?
 - Payor/PBM determines this
- If mail order is mandated by health plan
 - How will plan coordinate delivery with patient?
 - If pt homeless, is there option to mail to clinic or local pharmacy



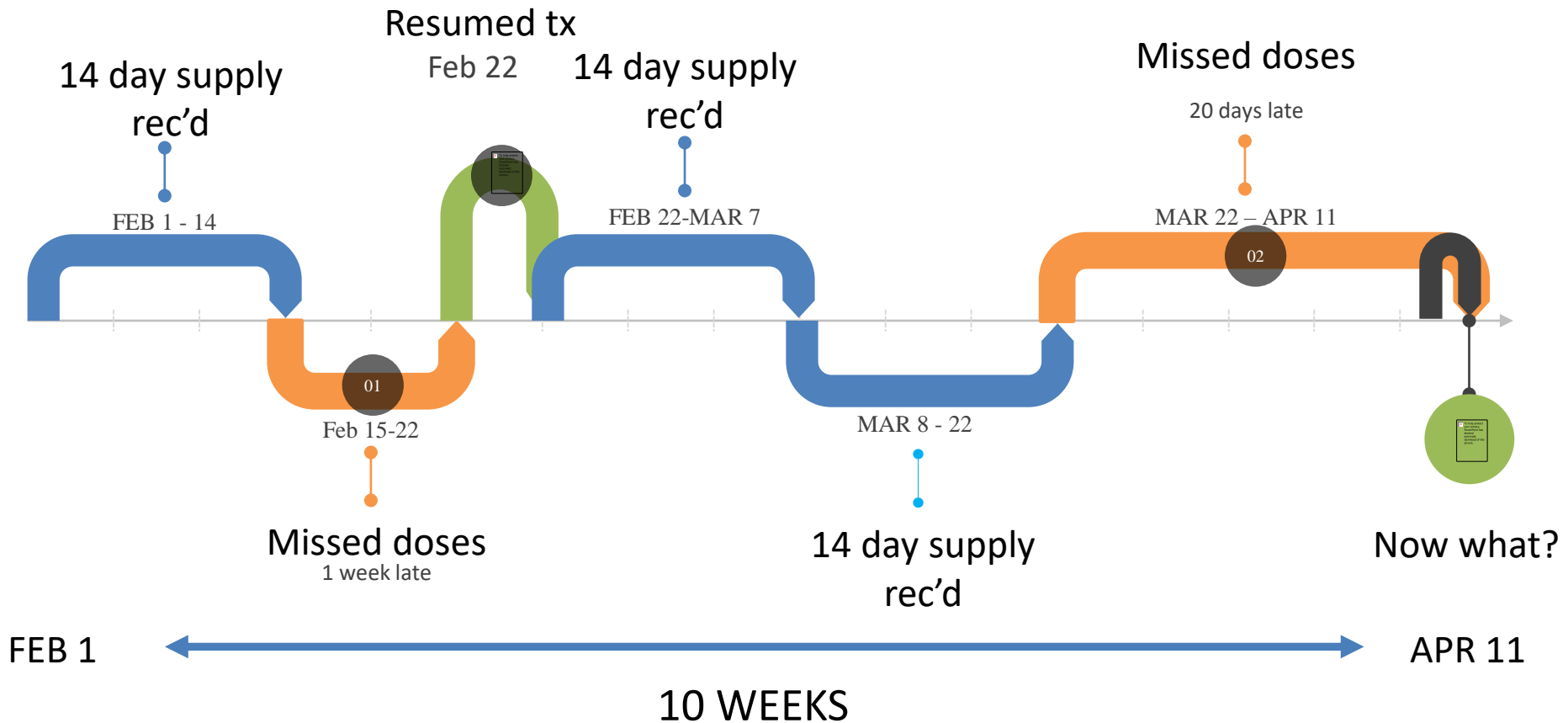
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SUMMARY

- Treatment lapses/gaps appear to be common (>1/10 cases) among HEPline calls received
- Best approaches to HCV treatment interruptions are not addressed in current HCV treatment guidance
- ANCHOR and other studies suggest perfect adherence not needed to achieve SVR12, but need to identify outer bounds of missed doses
- Reasons for treatment lapses varied but most commonly involved substance involvement/relapse and medication access/supply issues
- Gaps in care coordination evident among patient, provider(s), pharmacy, case management, etc.
- To minimize treatment gaps, consider optimizing:
 - Treatment of substance involvement, e.g. co-location of SUD treatment or use telemedicine for co-management
 - Care coordination (panel management, treatment navigators, case management) in primary care settings
 - Linkage to dispensing pharmacy for prescription coordination

Case A – Treatment interruption timeline



QUESTION → What is best approach?



HEPline Case “A” - Advice

- Discussed with our team’s hepatologist, ID physician, a senior PharmD (very experienced in HCV care)
- Acknowledged to caller that there is no clear evidenced-based answer for “next steps” → recall pt took about 6 weeks worth of GLE/PIB over a 10-11 week timespan
- Advised to check VL now, consider doing resistance testing and gave option to 1) complete last 2 weeks of GLE/PIB or 2) wait to see if pt cleared and if not can offer rescue therapy with SOF/VEL/VOX

OUTCOME → pt achieved SVR12!



CLINICIAN-TO-CLINICIAN ADVICE

Thank you!

To learn more, please visit www.nccc.ucsf.edu

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U10HA30039-03-01 (AIDS Education and Training Centers National Clinician Consultation Center) in partnership with the HRSA Bureau of Primary Health Care (BPHC) awarded to the University of California, San Francisco.

Clinician resources: the National Clinician Consultation Center... ...and more!

September 8, 2020

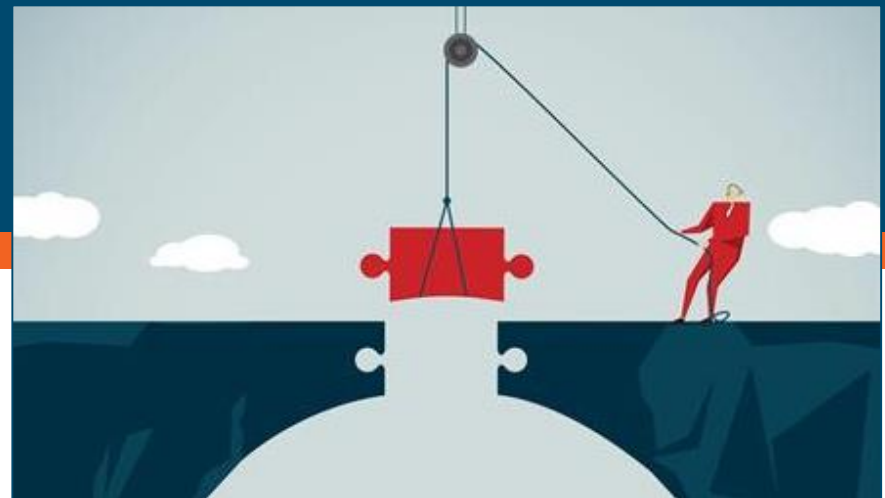
Carolyn Chu, MD, MSc, FAAFP | Clinical Director

University of California – San Francisco



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**Provider support/capacity-building is
a cornerstone for improving
treatment access and health
outcomes**





NATIONAL VIRAL HEPATITIS

ACTION PLAN

2017-2020



GOAL 1



PREVENT NEW VIRAL HEPATITIS INFECTIONS



GOAL 2



REDUCE DEATHS AND IMPROVE THE HEALTH OF PEOPLE LIVING WITH VIRAL HEPATITIS



GOAL 3



REDUCE VIRAL HEPATITIS HEALTH DISPARITIES



GOAL 4



COORDINATE, MONITOR, AND REPORT ON IMPLEMENTATION OF VIRAL HEPATITIS ACTIVITIES

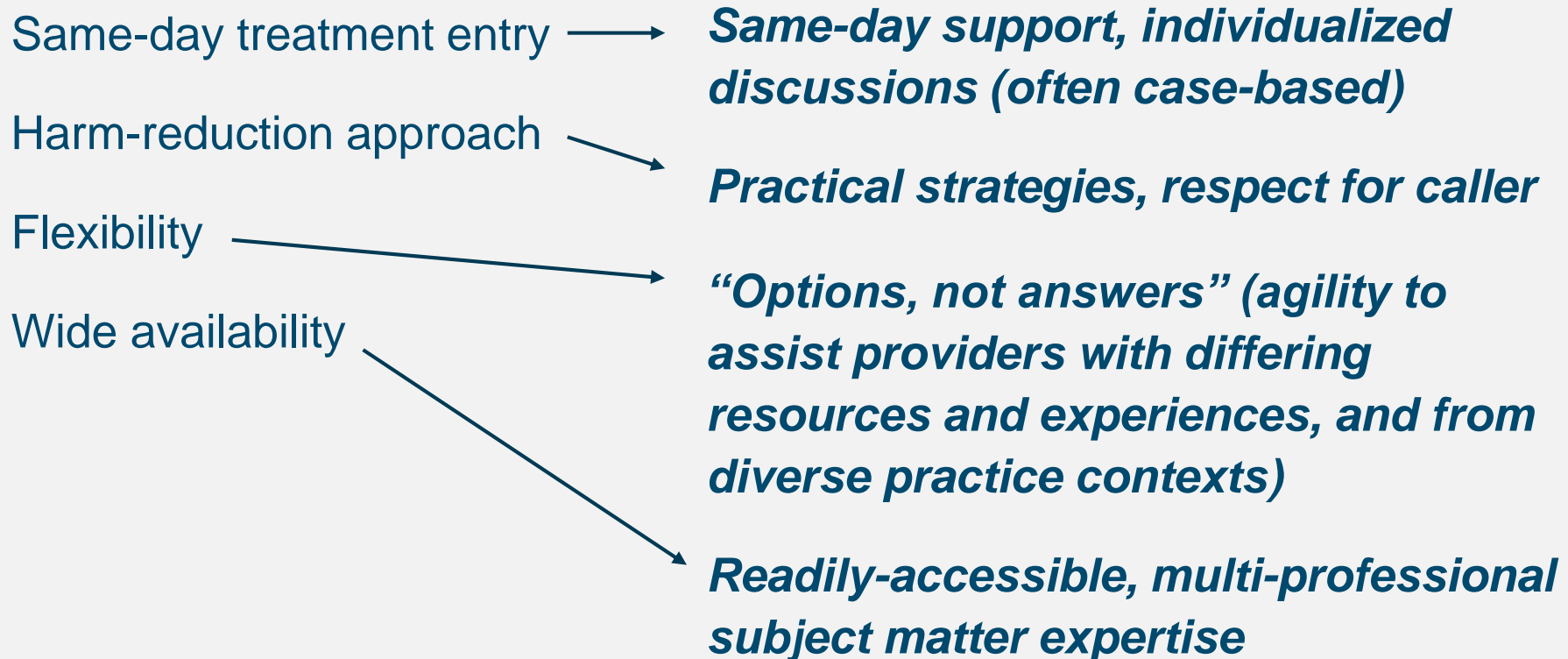
Challenges in Addressing Viral Hepatitis

The Action Plan also seeks to address a number of challenges that must be confronted as we work to improve our national response including:

- Limited data
- Low provider awareness and low public awareness and perceived risk
- Limited public health and health system response

- The perceived high costs of treatment and the large numbers of people chronically infected
- Stigma and discrimination
- Opioid epidemic

Our guiding principle: “low-threshold” support



NCCC caller feedback

"This service is amazing and so very helpful. I have used it several times and always come away feeling informed and ready to provide the best care to my patients."

"So thankful for this resource! Timely, helpful, and clear guidance from experienced experts – so easy to access and great response time!"

"The person I spoke to was so nice, supportive, and well-informed. I was nervous that my question was kind of a dumb one or something I should have known, but she didn't make me feel like that at all. It was a great experience."

"I view this group as a lifeline when I have questions – it's a fabulous resource for busy providers!"

"The consultant I spoke with saved my day. The care and concern I received was astounding, the consultant went above and beyond to help me and my patient."

So— who operates the national HCV, Substance Use, and HIV Warmlines?



Founded in 1990s at San Francisco General Hospital; Department of Family & Community Medicine, University of California San Francisco

- One of the first free, nationally accessible provider-facing resources to address HIV-specific questions at the point of care
- Any clinician is welcome to call (all experience levels/backgrounds/settings)

Founded in 1990s at San Francisco General Hospital; Department of Family & Community Medicine, University of California San Francisco

- One of the first free, nationally accessible provider-facing resources to address HIV-specific questions at the point of care
- Any clinician is welcome to call (all experience levels/backgrounds/settings)

Clinical depth across multiple domains: 500+ years of collective experience

- HIV
- Viral hepatitis
- Substance use
- Primary care
- Behavioral health

Experience with safety net health centers, Ryan White-funded programs, local health departments, correctional settings, tribal communities/providers

Multi-disciplinary, multi-professional consultants

Principal consultants include highly experienced primary care & specialty-boarded physicians, specialty clinical pharmacists, advanced practice nurses



How can providers access our HCV tele-consultation services?



Dial (844) HEP-INFO

Hours of operation: 9am-8pm EST | Mon-Fri

We ask callers for basic demographic and practice information for internal record-keeping purposes
(all calls are confidential; no PHI obtained)

-- OR --



Submit cases/inquiries online: nccc.ucsf.edu

Callers don't need to:

Sign-up in advance

Clear their clinic schedules

Memorize a patient's medical chart/history

Limit inquiries to complex scenarios or patient-specific questions (*general questions are welcome!*)

Download any apps or utilize special technology/IT equipment

What to expect:

Professional, compassionate consultants

Evidence-informed, practical guidance

Individualized support to help develop tailored treatment plans

We are happy to receive f/u calls

If helpful, consultants may send f/u information by email: resources, articles

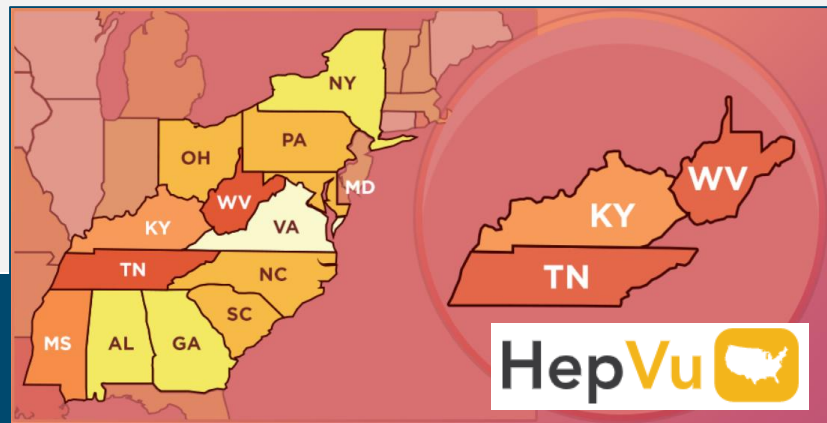


Things we cannot do

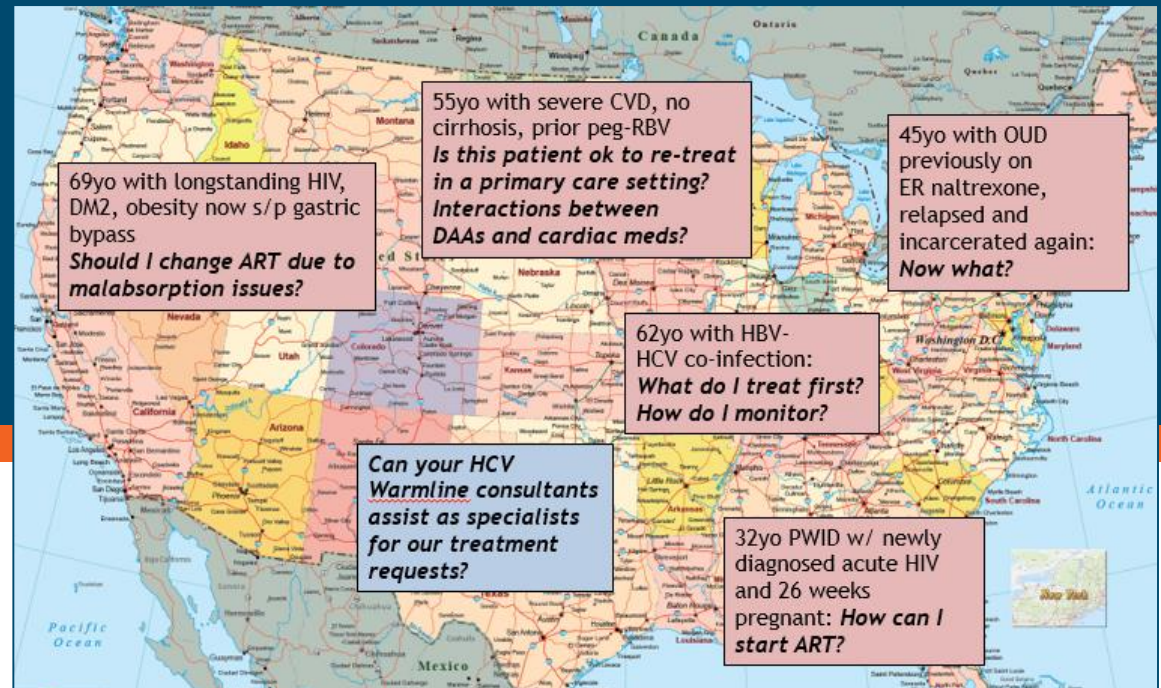
- Provide direct assistance with patient referrals (except perinatal HIV)
→ *happy to share provider locator resources*
- Offer medico-legal counsel → *may be able to share information on best practices, other references*
- Speak with/advise patients → NCCC does not offer direct “consultant to patient” services (our consultants do not evaluate, diagnose, or treat callers’ patients // no access to patient records)
- Limited availability for formal individual/group trainings → *happy to share information on local educational opportunities/resources*

Common consultation topics: HCV

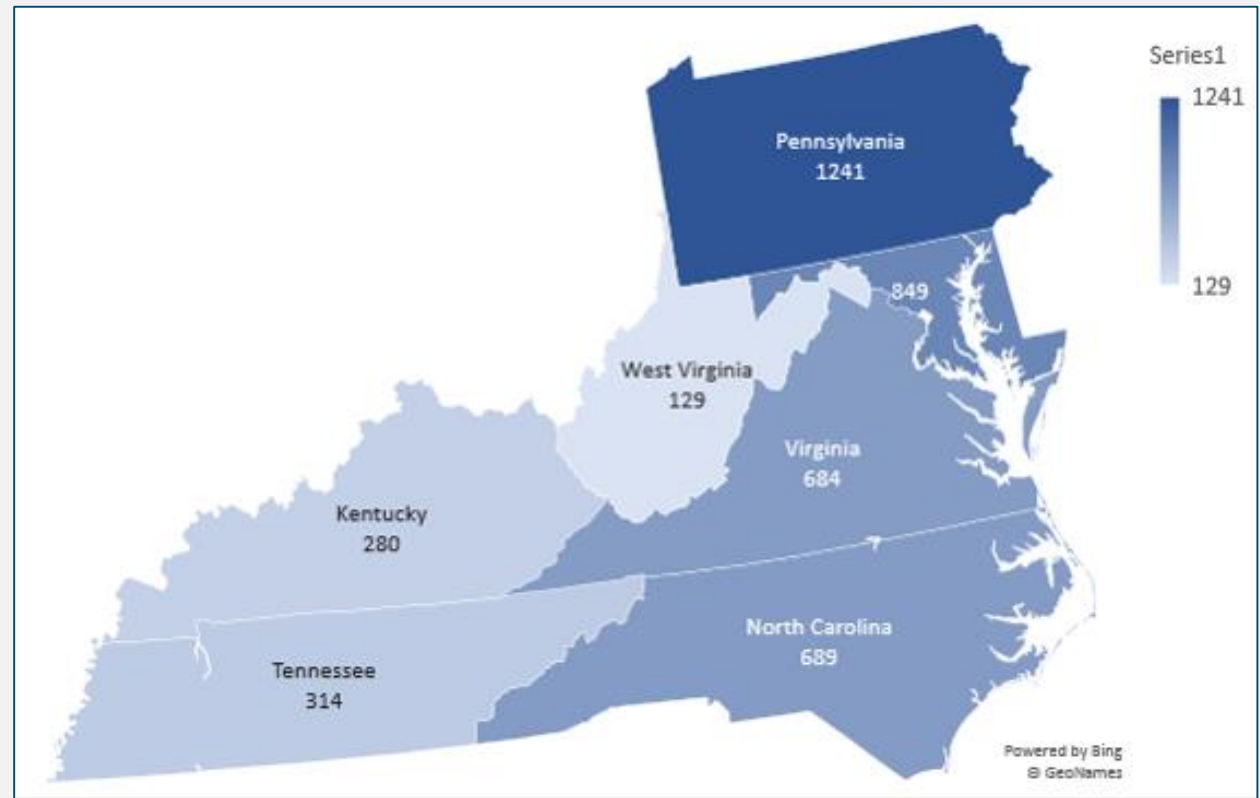
- **Initial treatment, retreatment, reinfection** (therapy options, timing/duration)
- **Liver disease staging** (non-invasive approaches, discordant testing results)
- **Medication interaction** assessment, management
- **Missed doses** (how to avoid, how to manage) and **laboratory monitoring** before/during/after HCV treatment
- **HBV, HIV coinfection, perinatal HCV** (delivery considerations, breastfeeding)
- **Navigating treatment approval** process



NCCC data: quick snapshots

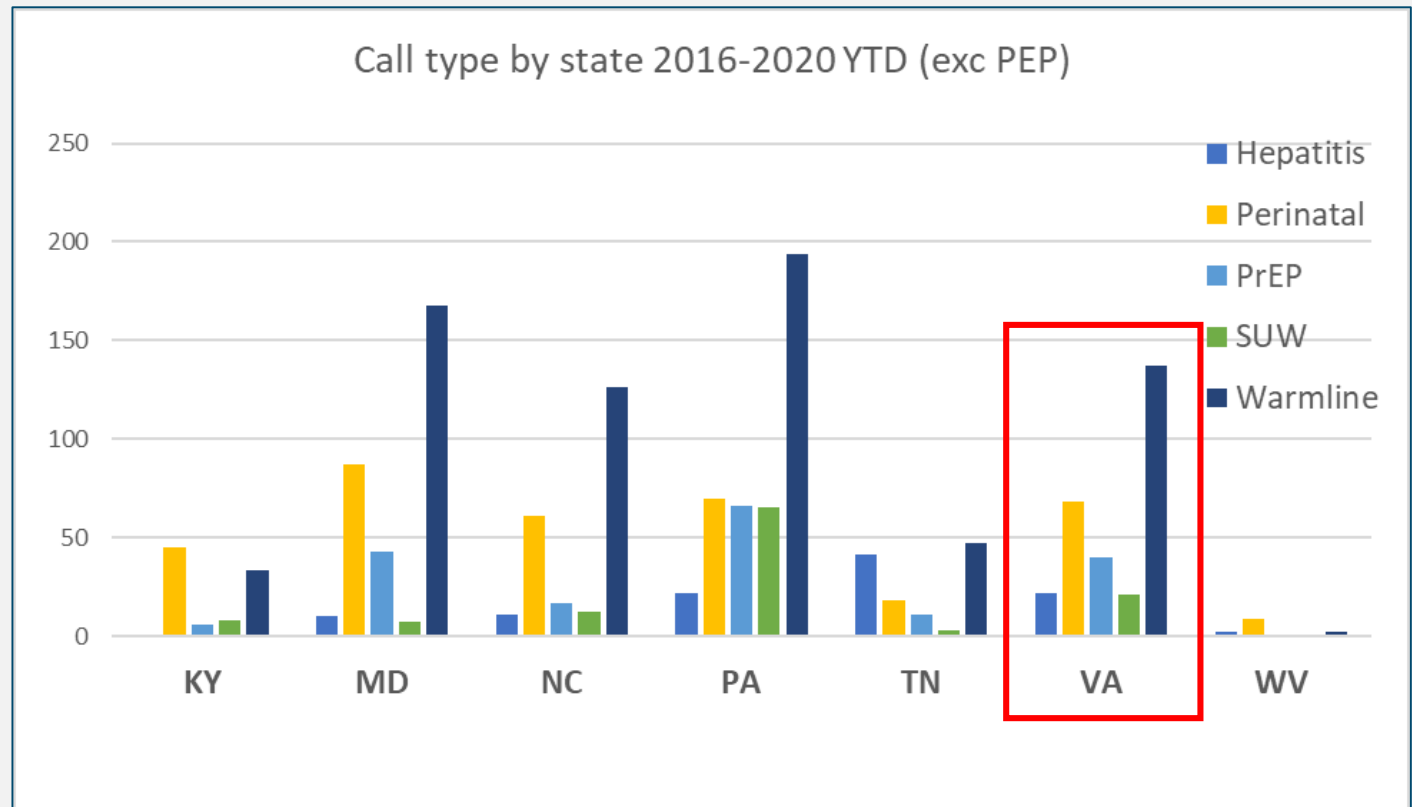


Calls* from Virginia and surrounding states



*FY17-20 | Includes non-occupational (sexual exposure, IDU) PEPlne calls; excludes occupational PEP calls

Calls (excluding all PEP) from Virginia and surrounding states, by consultation line



Late 2014: PrEPline

**Winter 2015:
Substance Use
Warmline**


**Fall 2017: Hepatitis C
Warmline**

Additional clinical resources




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AASLD/ISDA Guidelines



AASLD
AMERICAN ASSOCIATION FOR
THE STUDY OF LIVER DISEASES

HCV Guidance: Recommendations for
Testing, Managing, and Treating
Hepatitis C



IDSA
Infectious Diseases Society of America

Home ▾


Test, Evaluate, Monitor ▾

Treatment-Naïve ▾

Treatment-Experienced ▾

Unique & Key Populations ▾

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New and updated:
[Updated Testing Recommendations](#)
Review new HCV screening guidance from the AASLD and IDSA.

Search the Guidance

Enter your keyword

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06
Nov

What's New, Updates and Changes to the Guidance

24
May

What's New, Updates, and Changes to the Guidance

This version of the guidance has been updated to reflect new testing and management.... [read more](#)

Start Here: Choose a patient profile from the menu above. ↑

Welcome to HCVGuidelines.org

The AASLD and IDSA in partnership with the panel have created an updated web experience to facilitate easier and faster access to this important resource. Please select a patient profile from the menu above, click on a guidance section below, or use the search box to begin.

Contents and Introduction - *Select a Page*

Testing, Evaluation, and Monitoring of Hepatitis C - *Browse Topics*


Initial Treatment of HCV Infection - *Choose Patient Genotype*

Retreatment of Persons in Whom Prior Therapy Has Failed - *Choose Patient Genotype*

Management of Unique & Key Populations - *Review Recommendations*

Using the Guidance on Your Mobile Device

iPhone / iPad



Add a bookmark to your home screen:


Using Chrome:

1. While browsing the HCVGuidelines.org web site...
2. Press the 'three dots' icon in the top right corner.
3. Choose 'Add to home screen.'
4. Customize title and press 'Add.'


Using Firefox:


1. While browsing the HCVGuidelines.org web site...
2. Press the 'three dots' icon in the top right corner.


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 HEPATITIS C ONLINE


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 HCV Biology


 HCV Medications

 Course Modules

 Tools & Calculators

 Clinical Consultation

 Master Bibliography



Clinical Calculators

APRI, AUDIT-C; BMI, CAGE;
CTP, MELD, SAAG,
and more

Discover the Clinical Calculators »

○○○○●

AST Level (IU/L)

120

AST (Upper Limit of Normal) (IU/L)

40

APRI = $\frac{120}{40} \times 100 = 3.000$

Platelet Count ($10^9/L$)

100

See New CDC Hepatitis C Screening Recommendations

HCV Course Modules

Screening and Diagnosis of Hepatitis C Infection

For any clinician who may encounter persons with hepatitis C virus infection and would like to establish core competence in testing for hepatitis C, counseling patients on preventing hepatitis C transmission, and diagnosing acute hepatitis C infection.

[Overview / Quick Reference](#)
Rapidly access info about Screening and Diagnosis of Hepatitis C Infection

[Self-Study](#) **CNE/CME**
Track your progress and receive CE credit

Evaluation, Staging, and Monitoring of Chronic Hepatitis C

Intended for clinicians involved in long-term management of persons with chronic hepatitis C infection. Content includes initial evaluation, natural history, preventing liver damage, staging of liver fibrosis, evaluation of cirrhosis, surveillance for hepatocellular carcinoma, and recognition of extrahepatic manifestations.

[Overview / Quick Reference](#)
Rapidly access info about Evaluation, Staging, and Monitoring of Chronic Hepatitis C

[Self-Study](#) **CNE/CME**
Track your progress and receive CE credit

Management of Cirrhosis-Related Complications

[Overview / Quick Reference](#)
Rapidly access info about Management of Cirrhosis-Related Complications

[Self-Study](#) **CNE/CME**
Track your progress and receive CE credit

AETC National Curriculum



January 16, 2020

Philip Bolduc, MD, AAHIVS, New England AETC

This lesson will focus on the fundamentals of treating HCV infection. Understanding the treatment of HCV mono-infection is critical to mastering care of HIV/HCV co-infection.



Core Competency 4: HCV Treatment

Lesson 1: Fundamentals of Hepatitis C Virus Treatment



July 2017

Updated: December 2018, January 2020



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[Section 4: HCV Treatment](#)

[Fundamentals of HCV Treatment](#)

[Special Considerations When Treating HIV/HCV Co-infection](#)

[HCV Treatment Guidelines and Consultation Resources](#)

[Test Your HIV/HCV Treatment Knowledge](#)

[Section 5: Recommendations for Subpopulations of HIV/HCV Co-infected Persons](#)


[Section 6: Addressing Barriers for Co-infected People of Color](#)


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with this quick survey**

HEP Drug Interactions (Univ of Liverpool)

 **HEP Drug Interactions**

 UNIVERSITY OF LIVERPOOL













Interaction Checker →

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www.covid19-druginteractions.org - a new website for drug interactions with experimental agents used to treat COVID-19.

Having trouble viewing the interactions? [Click here for the Interaction Checker Lite.](#)

HEP Drugs	Co-medications	Drug Interactions
<input type="text" value="Search HEP drugs..."/>	<input type="text" value="Search co-medications..."/>	<input type="checkbox"/> Check HEP/HEP drug interactions
<input checked="" type="radio"/> A-Z <input type="radio"/> Indication <input type="radio"/> Trade	<input checked="" type="radio"/> A-Z <input type="radio"/> Class	Drug Interactions will be displayed here
Selected HEP Drugs will be displayed here.	Selected Co-medications will be displayed here.	
<input type="checkbox"/> Adefovir 	<input type="checkbox"/> Abacavir 	
<input type="checkbox"/> Daclatasvir 	<input type="checkbox"/> Abiraterone 	
<input type="checkbox"/> Elbasvir/Grazoprevir 	<input type="checkbox"/> Acalabrutinib 	
<input type="checkbox"/> Entecavir 	<input type="checkbox"/> Acamprosate 	
<input type="checkbox"/> Glecaprevir/Pibrentasvir 	<input type="checkbox"/> Acarbose 	
<input type="checkbox"/> Lamivudine (HBV) 	<input type="checkbox"/> Acebutolol 	

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HIV-HCV treatment interactions (Toronto)

HEPATITIS C AGENTS

HEPATITIS C AGENTS

	INSTIs		NNRTIs		PIs	RTI	
	<ul style="list-style-type: none"> • BICTEGRAVIR (Biktarvy) • DOLUTEGRAVIR (Tivicay, Triumeq, Juluca) • RALTEGRAVIR (Isentress) 	<ul style="list-style-type: none"> • ELVITEGRAVIR/COBICISTAT (Stribild, Genvoya) 	<ul style="list-style-type: none"> • DORAVIRINE (Pifeltro, Delstrigo) • RILPIVIRINE (Edurant, Complera, Odefsey, Juluca) 	<ul style="list-style-type: none"> • EFAVIRENZ (Sustiva, Atripla) • ETRAVIRINE (Intelligence) • NEVIRAPINE (Viramune) 	<ul style="list-style-type: none"> • ATAZANAVIR (Reyataz/Norvir, Evotaz) • DARUNAVIR (Prezista/Norvir, Prezcobix, Symtuza) • LOPINAVIR (Kaletra) 	<ul style="list-style-type: none"> • TENOFOVIR DISOPROXIL, TDF (Viread, Truvada, Atripla, Complera, Delstrigo, Stribild) 	<ul style="list-style-type: none"> • TENOFOVIR ALAFENAMIDE, TAF (Descovy, Biktarvy, Genvoya, Odefsey, Symtuza) • ABACAIR (Kivexa, Ziagen, Triumeq)

DIRECT ACTING ANTIVIRALS (DAAs)

• Glecaprevir + pibrentasvir (Maviret)				Potential for ↓ glecaprevir, pibrentasvir	Potential for ↑ glecaprevir, pibrentasvir		
• Ledipasvir + sofosbuvir (Harvoni)						Potential for ↑ tenofovir	
• Velpatasvir + sofosbuvir (Epclusa)				Potential for ↓ velpatasvir		Potential for ↑ tenofovir	
• Velpatasvir + voxilaprevir + sofosbuvir (Vosevi)				Potential for ↓ velpatasvir, voxilaprevir	darunavir Atazanavir, lopinavir: potential for ↑ voxilaprevir	Potential for ↑ tenofovir	
• Elbasvir + grazoprevir (Zepatier)		Potential for ↑ elbasvir, grazoprevir		Potential for ↓ elbasvir, grazoprevir	Potential for ↑ elbasvir, grazoprevir		

Project ECHO

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Project ECHO at UVA

Project ECHO® (Extension for Community Healthcare Outcomes) helps democratize medical knowledge and develops specialty care capacity in underserved communities. At UVA, Project ECHO programs use [Zoom®](#) videoconferencing technology to connect our specialists to primary care providers around Virginia.

About the Trainings

Our ECHO programs recruit a cohort of participants for regular remote mentoring sessions, usually weekly or biweekly. Each session is comprised of a brief didactic presentation by the specialist expert, followed by the presentation and discussion of de-identified sample cases. The specialist experts act as mentors, training community providers to provide care in clinical areas previously outside their expertise.

Learn more: Watch the ECHO [video](#).

CME Credits

Most sessions offer continuing medical education (CME) credits, maintenance of certification (MOC) credits, and continuing nursing education (CNE) credits.

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Thank you!

For more information: nccc.ucsf.edu

Carolyn.Chu@ucsf.edu (Carolyn Chu, Clinical Director/PI)



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Translating science into care

HEPC Project ECHO

MANAGING HEPATITIS C IN PRIMARY CARE

TERRY KEMP-KNICK, BSN-BC, MPH UVA

Virginia Hepatitis C Education & Patient Connection (HEPC)



We started as a collaboration between VDH and UVA to help provide treatment access to people with hepatitis C infection in rural areas of SWVA via telemedicine.

We began training providers and support staff to continue to increase capacity to treat HCV.

We are now working with the Department of Corrections with a Referral on Release program. To help those that were unable to be treated while incarcerated to find treatment for HCV close to home upon release.

You can see all of our programs at www.virginiahepc.com

Virginia Project ECHO Extension for Community Health Outcomes

Project ECHO



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Empowering clinics to offer access to HCV treatment locally

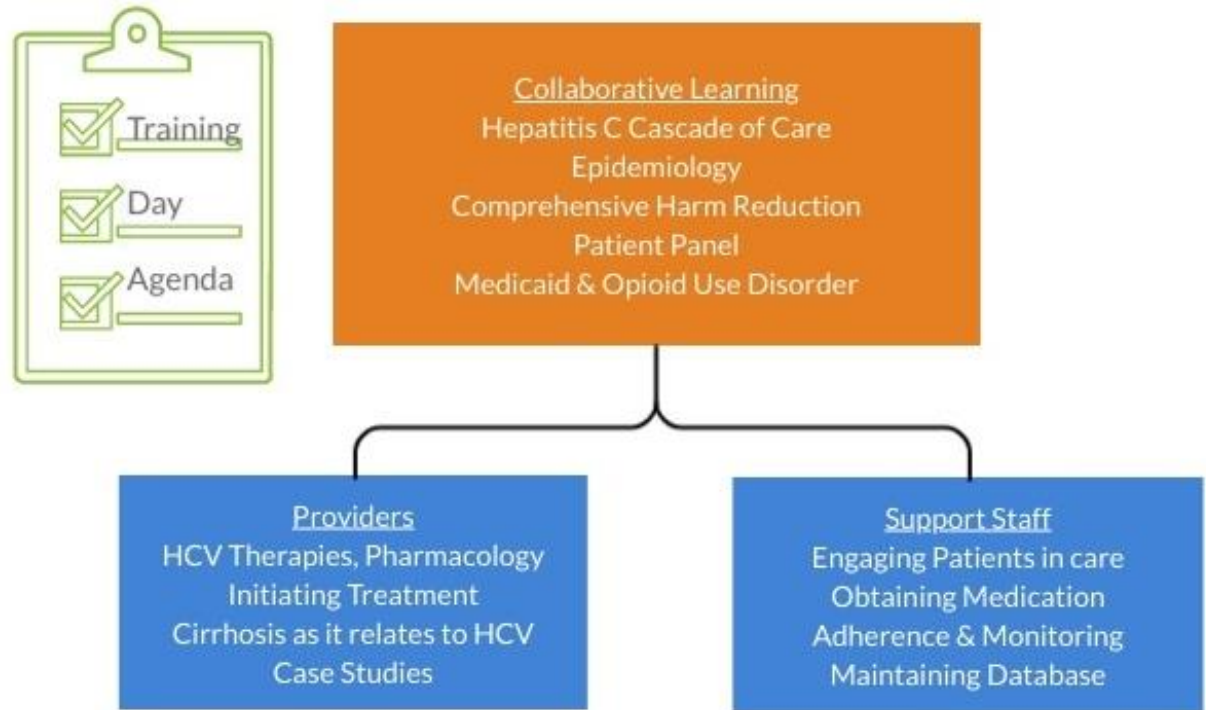
COVID has made other plans for us: As the ability to meet in larger groups is not certain in these times, we will hold our next training session via ECHO webinar- we will meet for one hour weekly for 6 weeks



Next training dates will be in October- TBD

There is a sheet to sign up if you are interested on our website under Programs: HEPC Training

Clinic teams learn general information together, then separate for information to maximize their understanding of the role they have in ensuring successful implementation of HCV treatment in their clinic setting



Monthly ECHO Call 3rd Wednesday of each month 4:00- 5:00 pm

We ask that our independently treating providers send us any interesting cases they have encountered prior to the date of the call. We review these with the group to expand everyone's understanding and abilities.

We also present new education during this time to increase the depth of knowledge on treating hepatitis C.

Registration for ECHO is only required once, you will then have access to all content- and to future sessions

Registration Link:

<https://connect.VirginiaProjectECHO.org/Series/Registration/210>

Next Training Will be via ECHO –Tentative Dates

Tuesday October 6	4:00-5:00 PM	
Tuesday October 13	4:00-5:00 PM	
Tuesday October 20	4:00-5:00 PM	
Wednesday October 21	4:00-5:00 PM	Monthly ECHO Call
Tuesday October 27	4:00-5:00 PM	
Tuesday November 3	GO VOTE NO CLASS	
Tuesday November 10	4:00-5:00 PM	
Tuesday November 17	4:00-5:00 PM	
Wednesday November 18	4:00-5:00 PM	Monthly ECHO Call

QUESTIONS??

Contact information:

Terry Kemp Knick, BSN-BC, MPH

tmk2s@hscmail.mcc.Virginia.edu

434-305-5561

www.virginiahepc.com

QUESTIONS?

Hepatitis C Provider List

DMAS has developed a survey to identify Medicaid providers interested in being included on a publicly available list for Medicaid members seeking Hepatitis C treatment. Our goal is to address the increasing Hepatitis C crisis by facilitating referrals to Hepatitis C treatment for members.

- Provider's name, email, and phone number will be included on the list.
- At the close of today's event, you will be directed to the survey. Press 'continue' in Webex when prompted so that you can be directed to the external RedCap survey.
- The survey will also be emailed if you are unable to complete it today.
- Participation and inclusion on the Hepatitis C provider list is voluntary.
- Please complete the survey by **September 15, 2020**

Survey link: <https://www.survey.dmas.virginia.gov/surveys/?s=PEFRN8R3Y8>

If you have any questions or concerns about the survey, please contact Jason Lowe, SUPPORT Act Grant Manager, at SUPPORTGrant@dmas.virginia.gov